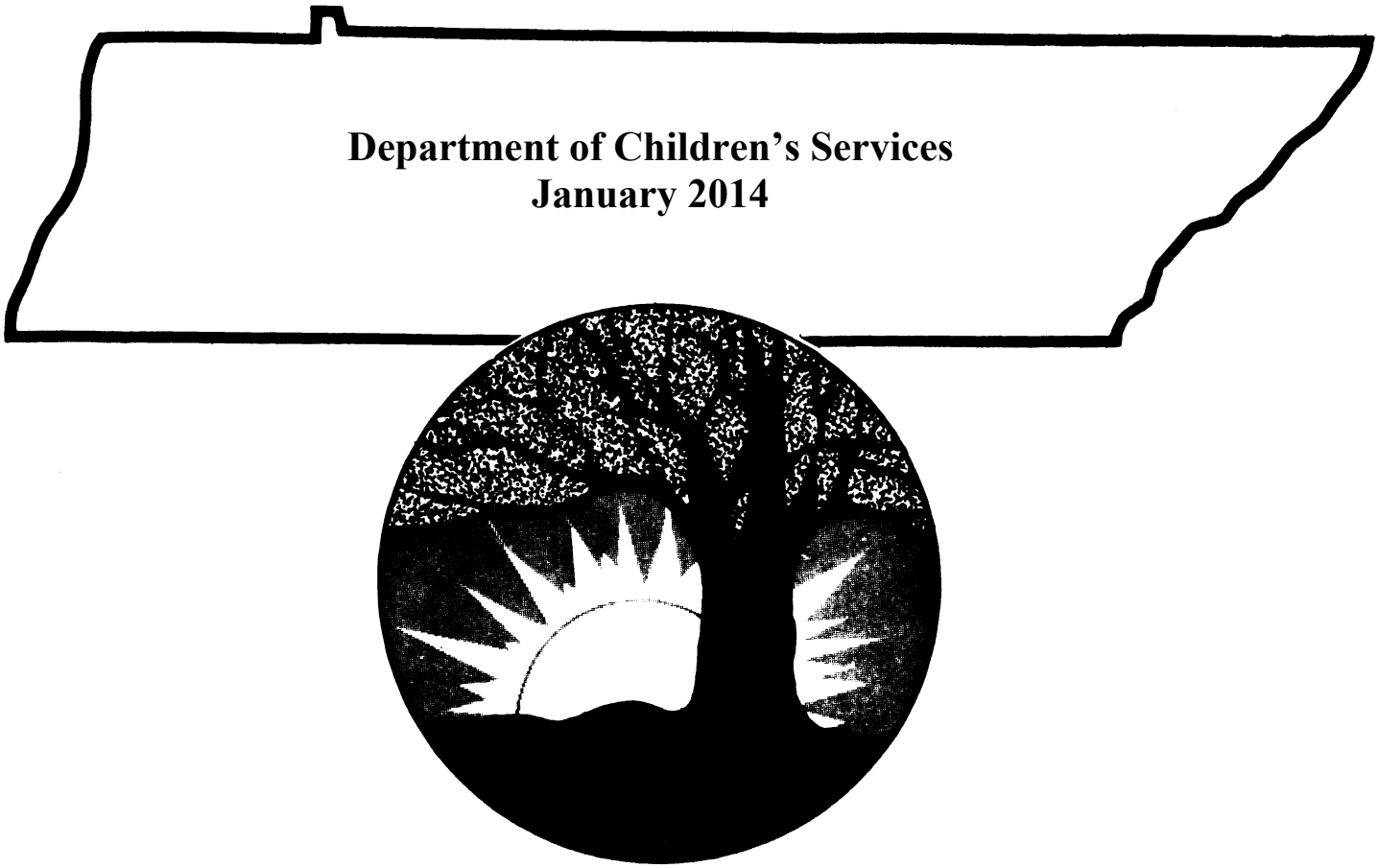
PERFORMANCE AUDIT

Department of Children's Services
January 2014



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January 13, 2014

The Honorable Ron Ramsey
Speaker of the Senate
The Honorable Beth Harwell
Speaker of the House of Representatives
The Honorable Mike Bell, Chair
Senate Committee on Government Operations
The Honorable Judd Matheny, Chair
House Committee on Government Operations
and
Members of the General Assembly
State Capitol
Nashville, Tennessee 37243
and
The Honorable James M. Henry, Commissioner
Department of Children's Services
7th Floor, Cordell Hull Building
Nashville, Tennessee 37243

Ladies and Gentlemen:

Transmitted herewith is the performance audit of the Department of Children's Services. This audit was conducted pursuant to the requirements of Section 4-29-111, *Tennessee Code Annotated,* the Tennessee Governmental Entity Review Law.

This report is intended to aid the Joint Government Operations Committee in its review to determine whether the Department of Children's Services should be continued, restructured, or terminated.

Sincerely,

Deborah V. Loveless

Deborah V. Loveless, CPA
Director

DVL/dlj
12-104

State of Tennessee

Audit Highlights

Comptroller of the Treasury | Division of State Audit

Performance Audit
Department of Children's Services
January 2014

AUDIT OBJECTIVES

The objectives of this audit focused on key functions of the department. The audit work was divided into four major areas: (1) Divisions of Child Safety and Child Health, (2) Administrative Functions, (3) Division of Juvenile Justice, and (4) Division of Child Programs.

FINDINGS

Divisions of Child Safety and Child Health

The Department Can Improve Investigation Thoroughness

While some child safety investigations appear to be conducted thoroughly, others appear to be missing key documentation and may not be as thorough as possible. Auditors conducted an in-depth review of electronic and paper documentation for 20 high-risk investigations from across the state. Our review found that two cases were not investigated, documented, and/or supervised as thoroughly as needed. It is critical that child safety investigations are conducted in a timely and thorough manner because of the nature of the child abuse and neglect allegations that trigger a child safety investigation. Our review also identified two cases in which key documentation was only stored in paper format and was not entered into the Tennessee Family and Child Tracking System (TFACTS). Investigations need to be consistently and completely documented in order to legally support and uphold the need to remove an at-risk child from his or her home and officially identify the perpetrator in state records. Additionally, the department does not currently aggregate, analyze, and then disseminate the results of internally heard appeals/reviews of administrative decisions finding that a person has committed child abuse or neglect. Aggregating and analyzing the results of such reviews could help the department identify where there are weaknesses in its investigation results and revise its policies, procedures, and training as needed (page 9).

The Department Can Improve Some Child Protective Investigative Teams' Operations

The department works with local child advocacy centers to coordinate Child Protective Investigative Teams (CPITs) who jointly conduct child sex abuse and severe child abuse investigations. However, these teams differ in their levels of attendance and how they operate. To obtain the opinions of professionals who work most closely with the teams, the auditors selected a random, judgmental

sample of coordinators from 15 of the state's 95 counties including center and department employees. Seven coordinators reported that some mandated groups do not consistently attend team meetings. Additionally, some teams function in a manner inconsistent with the teams' purpose. For example, some coordinators reported that although the teams are intended to assist the investigative process, the department sometimes waits until an investigation is finished to bring the case before the team. Finally, those teams coordinated primarily by department staff, because no center exists in the local area, are not required to conduct semi-annual self-evaluations, as are center-managed teams. In addition to addressing these differences, the department needs to use its new training, its statewide team advisory board, and its community relations analyst position to ensure all CPITs act consistently and effectively. The department also needs to continue to take steps to correct the computer interface between the centers and the department to ensure the centers are notified of all child abuse cases requiring team investigation (page 13).

The Department Needs to Better Track Child Abuse and Neglect Referrals Faxed in to the Child Abuse Hotline

While the Child Abuse Hotline receives the overwhelming majority (approximately 93%) of child abuse and neglect allegations (referrals) through a telephone hotline, some allegations are received through the department's Internet web page, facsimile, and mail. While the hotline appears to handle most referrals received by fax or Internet in a timely and appropriate manner, there are discrepancies in some cases' tracking documentation that need to be addressed. These referrals are tracked by a combination of manual and computerized logs and documentation. Auditors tested 60 referrals received through methods other than telephone in December 2012 and March 2013 and found that the majority (52) were processed in a timely and appropriate manner. However, auditors could not properly assess the remaining referrals because of discrepancies in their tracking records. While these discrepancies could be attributed to simple human errors, the department cannot absolutely ensure these referrals were handled in a timely or appropriate manner. Because these referrals potentially involve children at high risk, the department needs to improve how it tracks fax and Internet referrals to minimize discrepancies (page 17).

The Department Has Not Complied With All Legislative Reporting Requirements

The department did not report all statutorily required information to the General Assembly during fiscal years 2011-2013. For example, the department did not report the deaths of children in its custody to the child's legislators as required by Section 37-5-124, *Tennessee Code Annotated*, until this requirement was publicized in a high-profile media report in late 2012. However, the department did provide other statutorily required reports. For example, the department appears to be complying with Section 37-5-129, *Tennessee Code Annotated*, which requires it to submit any new departmental policies within 60 days of adoption to the Judiciary Committee of the Senate and the Civil Justice Committee of the House of Representatives. Some provisions in statute are no longer relevant, and the General Assembly may wish to consider eliminating them and clarifying others, especially those related to the department's 2009 implementation of the multi-level response system (page 20).

<u>Administrative Functions</u>

Although the Department Has Made Efforts to Improve the Tennessee Family and Child Tracking System, Additional Changes Are Needed to Ensure the System Is Fully Functional

Since implementing a new child welfare information system, the Tennessee Family and Child Tracking System (TFACTS), in August 2010, the Department of Children's Services has faced numerous documented system problems. While the department has worked to improve the system, users continue to report numerous issues negatively impacting both management efficiency and the day-to-day field

operations. Some of these problems include uncertainty about the reliability of system-generated reports, the system's inability to generate key reports, challenges locating information in the system, difficulty using the search function, and the system's slow speed. In addition, external reviewers continue to report areas where additional system improvements are needed (page 37).

Some of the Department's Background Check Files Lack Sufficient Documentation That Required Checks and Supervisory Reviews Had Been Completed, Raising Questions About the Appropriateness of Approval of Volunteers and Resource Homes Providing Services to Children

Sections 37-5-511(a)(1) and (2), *Tennessee Code Annotated,* require that "each person . . . applying to work with children as a paid employee with a childcare agency . . . or with the department [of Children's Services] in any position in which significant contact with children is likely in the course of the person's employment" should submit to a series of background checks. Through state law and departmental policy, these background checks apply to several groups including DCS employees and volunteers; private-provider employees and volunteers; DCS resource home parents and adult residents; private-provider resource home parents and adult residents; and direct-care vendors (i.e., those persons who directly provide services to children under the custody or supervision of the department). Auditors first reviewed the internal controls in place to determine whether the department's monitoring of these groups appeared adequate to reduce the risk of safety to children. If we did not determine that monitoring was adequate, we analyzed a sample of background check files to identify areas of weakness. We reviewed files for DCS volunteers; DCS resource home parents and adult residents; and private-provider resource home parents and adult residents, and found missing or inadequate documentation of completion of required background checks, approval of resource homes prior to all background checks being completed, and inadequate documentation of supervisory review. Because of these weaknesses, it was unclear whether some volunteers and resource homes should have been approved to work with children in the care of DCS (page 44).

The Department Should Reassess Its Policies and the Documentation Maintained in Adoption Assistance and Subsidized Permanent Guardianship Files to Ensure That the Necessary Information Is Required and Is Included in the Files

Adoption Assistance and Subsidized Permanent Guardianship payments provide financial support to families adopting children with special needs or assuming legal guardianship of children, respectively. Payments can include one-time expense reimbursements, medical benefits, or monthly payments. A standard board daily payment rate is applicable to most children, with a higher rate paid to those eligible for special or extraordinary rates. Ensuring that payments are justified and distributed correctly is essential to proper departmental spending. Our review of files for a sample of recipients receiving payments during the period July 1, 2012, through December 31, 2012, found missing or incomplete documentation that limited our ability to fully analyze the files and raised questions about the recipients' eligibility for the payments and the appropriateness of the payment amounts. Additional documentation and explanation provided by the department after our fieldwork was completed addressed some of the auditors' questions regarding recipients' eligibility, but questions remain regarding the documentation maintained in the files, and staff's compliance with the department's policies. The department has very specific, detailed requirements for documentation that needs to be included in the files; however, our review found that those requirements are not always met. If the department were able to simplify those requirements, focusing only on documentation that was absolutely needed, it could potentially streamline the process, decrease documentation, yet still ensure that vital documentation is maintained in the child's file (page 49).

Division of Juvenile Justice

The Department Is Not Meeting Probation and Aftercare Supervision Requirements for Youth Who Have Been Adjudicated Delinquent

Juvenile court judges assign the youth to DCS probation in lieu of committing the youth to the department's custody; also, youth are placed in the aftercare program as their custodial episode with the department ends. Our review focused on the adequacy of the supervision provided to the youth assigned to probation or aftercare. Supervision of these youth ensures the youth comply with the rules of probation, including consistent school attendance and regular drug screens, and improve their behavior. We reviewed a sample of 32 cases representing 162 months of department supervision. Overall, the department documented the minimum required contacts for only 57 out of 162 months of supervision (35%) reviewed. When a caseworker does not maintain regular contact with a youth, the primary caretaker, or a service provider, the caseworker may not be able to determine when additional assistance is needed, which could eventually lead to a judge placing the youth into the department's custody (page 60).

The Department Needs More Residential Treatment Options to Meet the Needs of Youth Who Have Been Adjudicated Delinquent

The Department of Children's Services' (DCS') Division of Juvenile Justice provides a range of services to youth that the juvenile courts have committed to the department for delinquent offenses. To assess the level of treatment resources available for youth who have been adjudicated delinquent, auditors randomly selected a sample of 5 of the 12 DCS regions and interviewed DCS staff responsible for placing those youth in custodial treatment within the 5 regions. The interviews revealed that DCS does not have sufficient treatment resources in all regions reviewed for youth who have been adjudicated delinquent. This lack of treatment resources has caused the department to place youth significantly far from their homes to receive needed treatment. Furthermore, it has contributed to treatment providers' ability to be selective in the types of youth they agree to serve and to youth sometimes remaining in detention facilities for extended periods. DCS staff responsible for network development is aware of the need for additional treatment resources and has plans to create a needs assessment for the regions; however, no formal needs assessment currently exists (page 63).

The Department Does Not Calculate a Recidivism Rate and Does Not Measure the Effectiveness of Custodial and Non-custodial Services Provided to Youth Who Have Been Adjudicated Delinquent

While the department has made progress toward defining and calculating the recidivism rate for youth released from the department's custody after being adjudicated delinquent, additional measures are needed to determine the short- and long-term outcomes and the effectiveness of all of the services provided to these youth. Because of the lack of measures in place for this population, the department cannot demonstrate that the treatment and services provided to youth who have been adjudicated delinquent are working as intended (page 66).

The Department Has Not Yet Ensured Full Compliance With the "Evidence-Based" Law, and Implementation Has Been Inconsistent

Chapter 585, Public Acts of 2007, required the Department of Children's Services to start a multi-year process of implementing practices and programs that have been scientifically proven, or are supported by research or theory, to reduce juvenile delinquency. The department was required to determine which of its current programs met the statutory requirements and report to the legislature no later than January 1, 2009. The department fulfilled that requirement; however, the law further requires the department to ensure that for fiscal year 2012-2013 (and each fiscal year thereafter), 100% of the funds

expended for delinquent juveniles (i.e., all delinquency programs) meet the statutory requirements for being evidence-based. Since the submission of the initial report, implementation has been inconsistent, with gaps in implementation progress. Although the department has clearly made progress since the initial passage of the law and has taken steps to move toward full implementation, the department has not yet fully complied with the evidence-based law (page 69).

Division of Child Programs

The Department Needs to Further Assess Foster Care Placement Needs and Monitor Private Provider Placement Practices

The department places children into foster care, depending on the child's needs, in a department or contract agency resource (foster) home or in placements that provide higher levels of care and/or a more restrictive environment. Auditors' review found that the department has appropriate processes in place to recruit and approve resource homes. However, department caseworkers report difficulties in placing certain types of children in the most appropriate settings, which could result in some children's needs not being fully met. For example, caseworkers consistently reported that there were not enough Level 3 residential care facilities to meet children's needs. Additionally, placement staff report that some private providers decline to accept children they believe will be difficult to treat or manage. A formal needs assessment for the department's regions could help the department effectively focus its efforts to develop additional placement and treatment capacity (page 76).

OBSERVATIONS AND COMMENTS

The audit also discusses the following issues:

Divisions of Child Safety and Child Health: (1) department policies and protocols regarding methamphetamine-exposed children's long-term medical needs; (2) Tennessee Child Abuse Hotline call wait times and call abandonment rates; (3) investigators' caseloads; (4) the new child death review process; and (5) statute and department policy inconsistencies in describing administrative findings of child abuse or neglect (page 25).

Administrative Functions: (1) improvements in department processes to detect and resolve payment issues; (2) the need to address gaps in the process for monitoring direct-care vendors; and (3) changes in the incident reporting process (page 53).

Division of Juvenile Justice: (1) additional non-custodial service capacity needed for youth who have been adjudicated delinquent and (2) the Division of Juvenile Justice's allocation of prevention grant funds (page 72).

Division of Child Programs: (1) resource parent recruitment; (2) Early and Periodic Screening, Diagnosis, and Treatment screenings; and (3) case manager visits with foster care children (page 80).

ISSUES FOR LEGISLATIVE CONSIDERATION

The General Assembly may wish to consider deleting or amending statutory reporting requirements associated with the department's pilot implementation of the multiple response system,

including Sections 37-1-406(m)(1)(g)(2), 37-5-603(b), and 37-5-605, *Tennessee Code Annotated* (page 23).

The General Assembly may wish to consider addressing variations in the terms used to describe the department's process of administratively finding that a perpetrator has committed child abuse or neglect, by changing the statutory language to be more consistent (page 34).

Performance Audit
Department of Children's Services

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Performance Audit
Department of Children's Services

INTRODUCTION

PURPOSE AND AUTHORITY FOR THE AUDIT

This performance audit of the Department of Children's Services was conducted pursuant to the Tennessee Governmental Entity Review Law, *Tennessee Code Annotated*, Title 4, Chapter 29. Under Section 4-29-235, the department is scheduled to terminate June 30, 2014. The Comptroller of the Treasury is authorized under Section 4-29-111 to conduct a limited program review audit of the agency and to report to the Joint Government Operations Committee of the General Assembly. The audit is intended to aid the committee in determining whether the department should be continued, restructured, or terminated.

OBJECTIVES OF THE AUDIT

All of the objectives for this audit are listed in Appendix 3 of this report. The objectives that are specific to each division are presented at the beginning of the respective section.

SCOPE AND METHODOLOGY OF THE AUDIT

The activities of the department were reviewed primarily for the period May 2007 through October 2013. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Methods used included

1. review of applicable legislation, policies and procedures, federal reports, and information from other states;
2. examination of the department's records, reports, files, and information summaries;
3. site visits to selected department regional offices; and
4. interviews with department staff, juvenile court judges, and other state, private agency, and judicial staff that interact with the department.

For our sample design, we used nonstatistical audit sampling, which was the most appropriate and cost-effective method for concluding on our audit objectives. Based on our

professional judgment, review of authoritative sampling guidance, and careful consideration of underlying statistical concepts, we believe that nonstatistical sampling provides sufficient, appropriate audit evidence to support the conclusions in our report. We present more detailed information about our methodologies in the individual report sections.

DEPARTMENTAL CHANGES AND AUDIT IMPACT

Over the course of this audit, the department underwent extensive organizational and managerial changes. After a period of intense media, legislative, and judicial scrutiny, the department's Commissioner resigned in February 2013, and the Governor appointed an Interim Commissioner. The Interim Commissioner was later appointed Commissioner of the department, and over the course of several months, the new Commissioner implemented numerous and substantial organizational changes. For example, the department was completely reorganized; at least one senior manager who had been released from state service by the prior Commissioner was rehired, while others were disciplined or reassigned; the child death review and child death count processes were overhauled; the Child Abuse Hotline was restructured; and the Tennessee Bureau of Investigation was incorporated into child safety investigator training.

The Comptroller of the Treasury's Division of State Audit typically performs post-audits, identifying and reporting past problems and recommending future improvements. However, because of the rapid pace of departmental change during the audit, auditors modified typical Sunset audit approaches to help ensure we included management changes in our analysis of department operations, where possible. While auditors attempted to remain up-to-date with management improvements, all file reviews and other audit work had to be conducted at some point in time, after which departmental changes may have continued to occur. However, auditors disclose in this report any subsequent, known process changes that may impact our results. Finally, auditors completed fieldwork in October 2013. Any subsequent management changes are generally not reflected in the report, unless otherwise noted.

ORGANIZATION AND STATUTORY RESPONSIBILITIES

The Department of Children's Services (DCS) was created in July 1996 as part of the Children's Plan initiative to provide services to children in state custody, as well as to those children who are at risk of entering state custody. It had approximately 4,500 employees and an estimated budget of $666 million in fiscal year 2013. The Department of Children's Services, as authorized by Section 37-5-102, *Tennessee Code Annotated*, serves as the state's primary system for providing services to the state's most at-risk children.

DCS reports that 8,917 children were in the department's custody as of October 31, 2013. The following table shows the number of children in custody by adjudication type.

Number of Children in Custody by Adjudication As of October 31, 2013	
Adjudication Type	
Dependent/Neglected	7,289
Delinquent	1,411
Unruly	128
None Given	89
Total	8,917

Source: DCS Mega Report.

DCS operations are organized into 12 regions (see the map on page 5) and 5 major departmental divisions: Child Safety, Child Health, Administrative Functions, Juvenile Justice, and Child Programs (see the organization chart on page 6). Among the department's major responsibilities is ensuring that children are safe and protected from abuse and neglect.

REVENUES AND EXPENDITURES

Department of Children's Services
Revenues by Source
For Fiscal Year 2012

Source	Amount	Percent of Total
State	$302,414,400	45.4%
Federal	115,049,100	17.3%
Other*	248,551,800	37.3%
Total Revenue	**$666,015,300**	**100.0%**

*Other includes interdepartmental revenue from TennCare and the Department of Education, as well as trust revenue from Social Security, Supplemental Security Income, and child support.

Source: *The Budget 2013-2014.*

Department of Children's Services
Expenditures by Program
For Fiscal Year 2012

Program	Payroll	Operational	Total
Administration	$30,443,100	$16,469,500	$46,912,600
Family Support Services	0	38,546,800	38,546,800
Custody Services	0	222,677,300	222,677,300
Needs Assessment	0	4,514,600	4,514,600
Adoption Services	2,500	84,809,500	84,812,000
Child and Family Management	165,157,500	52,975,100	218,132,600
John S. Wilder Youth Development Center	9,234,900	2,106,200	11,341,100
Taft Youth Development Center*	8,949,800	1,977,300	10,927,100
Woodland Hills Youth Development Center	9,011,600	2,315,000	11,326,600
Mountain View Youth Development Center	9,110,100	2,158,900	11,269,000
New Visions Youth Development Center**	2,894,600	746,700	3,641,300
Community Treatment Facilities	1,052,600	499,300	1,551,900
Major Maintenance	0	362,400	362,400
Total	**$235,856,700**	**$430,158,600**	**$666,015,300**

*Taft Youth Development Center closed in fiscal year 2012.

**New Visions Youth Development Center was integrated into the Woodland Hills campus in 2012.

Source: *The Budget 2013-2014.*

Department of Children's Services
Budget and Estimated Revenues
For Fiscal Year 2013

Source	Amount	Percent of Total
State	$297,029,900	46.6%
Federal	113,686,200	17.8%
Other*	226,261,400	35.6%
Total Revenue	**$636,977,500**	**100.0%**

*Other includes interdepartmental revenue from TennCare and the Department of Education, as well as trust revenue from Social Security, Supplemental Security Income, and child support.

Source: *The Budget 2013-2014.*

Department of Children's Services Regional Structure

Northwest Region - 9 Counties

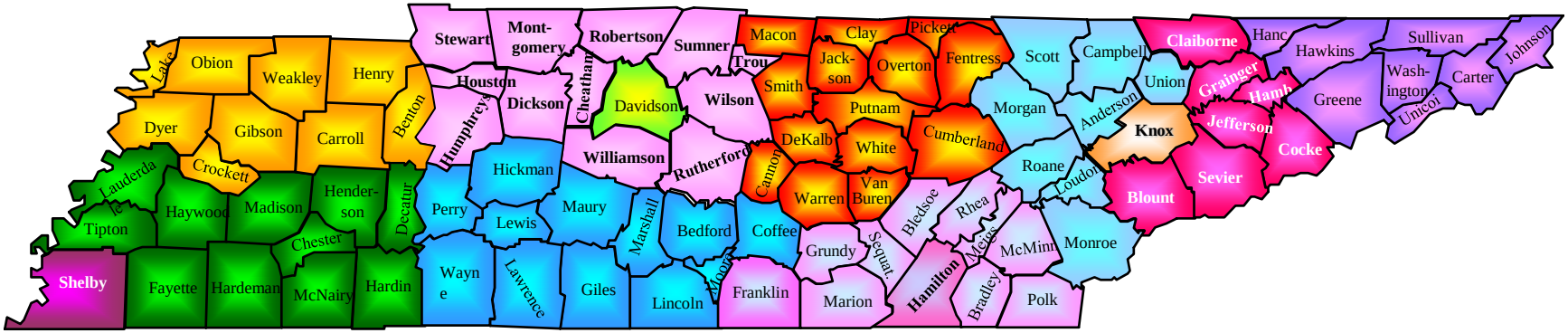
Davidson County Region/ Woodland Hills YDC / Nashville Transition Center / Special Investigations Unit

East Tennessee Region - 8 Counties

Mid-Cumberland Region - 12 Counties

Upper Cumberland Region - 14 Counties

Northeast Region - 8 Counties



Shelby County Region / Peabody

South Central Region - 12 Counties

Tennessee Valley Region - 11 Counties

Knox County Region

Southwest Region - 11 Counties / Wilder YDC

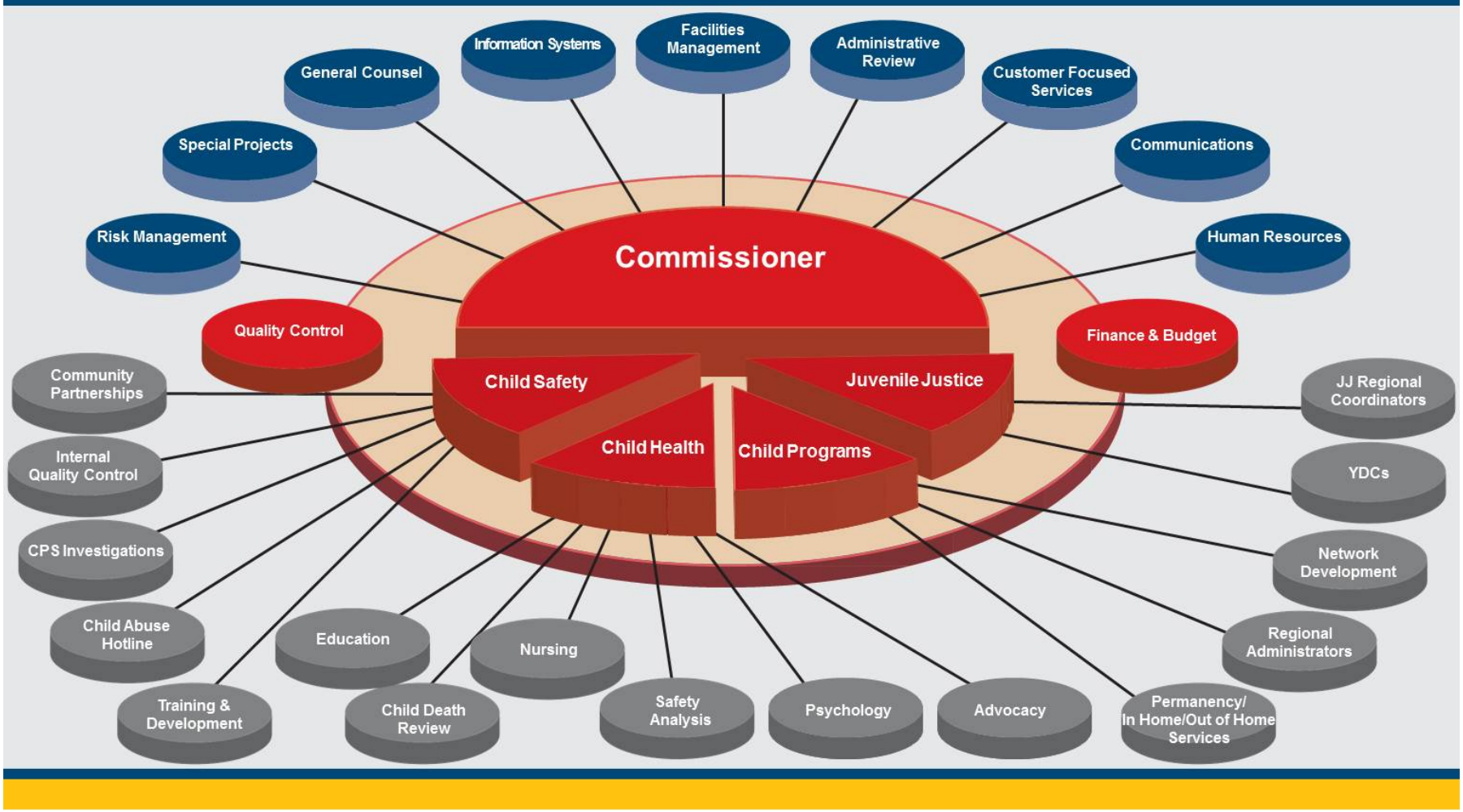
Smoky Mountain Region - 7 Counties / Mtn. View YDC

Source: Department of Children's Services. Current as of November 2013.

DCS | DEPARTMENT OF CHILDREN'S SERVICES

August 13, 2013

Organizational Framework



DIVISIONS OF CHILD SAFETY AND CHILD HEALTH

BACKGROUND

The Department of Children's Services' Division of Child Safety is responsible for the Child Abuse Hotline, Child Protective Services investigations, internal quality control, training and development, and community partnerships.

The Division of Child Health is responsible for child well-being, safety analysis, and advocacy.

Objectives

The objectives covered in this chapter were to

1. assess whether child safety investigations are completed as thoroughly as reasonably possible within existing guidelines and how investigations can be improved, including whether the current investigator caseload guidelines are appropriate and whether major substantiation policy language is consistent with statutory language;
2. assess whether Child Protective Investigative Teams are meeting their objectives and how they can be improved, especially in terms of attendance;
3. review how effectively the Child Abuse Hotline receives and classifies all referrals (to the extent possible), how the department is refining its operations, and if/how its operations can be further improved;
4. assess whether the department complies with key statutory legislative reporting requirements; and
5. identify and assess, to the extent possible, changes made to the child death review process.

Organization and Functions

Child Safety is organized into five units: Child Abuse Hotline, Child Protective Services investigations, community partnerships, internal quality control, and training and development. The Deputy Commissioner for Child Safety, who reports directly to the Commissioner, oversees the division.

The ***Child Abuse Hotline*** is a telephone call center, located in Nashville, which is available 24 hours a day, 7 days a week to receive reports of alleged child abuse and neglect. In addition to telephone calls, the hotline also receives reports by fax, internet, and mail. Call center caseworkers screen all reports and make several important determinations, including whether the allegation meets the statutory definitions of child abuse or neglect. If so, hotline

personnel determine if the referral should be assigned to a region for action, which includes investigation. During fiscal year 2013, the hotline reports it received over 107,000 reports of alleged child abuse or neglect.

The ***Child Protective Services investigations unit*** is responsible for examining allegations of child abuse and neglect that the hotline determines are potentially severe, would constitute child sexual abuse, could result in the child's removal from the home if proven true, or meet other similar criteria. Regional investigators examine the child's living situations, such as their family and home, as well as any specific alleged incident. Based on the investigation results, caseworkers and their supervisors make two determinations. First, they decide whether a child has been abused or neglected. If so, they can recommend that the child be removed from their family if specific criteria are met, subject to court approval. Second, if abuse or neglect occurred, the caseworkers and their supervisors decide whether a specific perpetrator can be conclusively identified. The department reports that it conducted more than 60,000 investigations in fiscal year 2013.

The Child Safety group also includes several other support groups, including an analyst who works with various ***community partners,*** such as child advocacy centers, the Second Look Commission, and citizen review panels. The ***internal quality control unit*** reviews the hotline and investigative functions to ensure they are meeting internally set qualitative and quantitative measures. Finally, the ***training and development unit*** works with the Tennessee Bureau of Investigation and others to provide and monitor hotline and investigative staff training.

The Division of Child Health is organized into six units: education, nursing, psychology, advocacy, safety analysis, and child death review. A Deputy Commissioner oversees these functions and reports to the Commissioner.

The ***education, nursing, and psychology units***, which prior to April 2013 were collectively referred to as the well-being unit, provide specialized support to the regional offices to ensure that children's psychological, medical, and educational needs are met. For example, in addition to other responsibilities, psychologists might interview children who are being considered for psychotropic drugs; nurses might monitor to ensure that all children receive required medical screening, and could consult with caseworkers on care given to medically fragile children; and education specialists might help with foster children's special education plans.

The ***advocacy unit*** assists the department in assuring that medically necessary medical and behavioral health care is provided to children in state custody by serving as the department's liaison with the Bureau of TennCare, including enrolling children for immediate eligibility for Medicaid clinical services; documenting and tracking all medical and behavioral appointments, visits, and clinical recommendations; and filing appeals regarding denied clinical services.

The ***safety analysis unit*** oversees the new ***child death review*** process, which went into effect in fall 2013. Analysts gather information about child deaths and conduct multi-disciplinary team meetings to review events from a systemic perspective, to determine why the death occurred and what the department can learn for the future. The teams are made up of

frontline DCS staff, supervisors, administrators, independent physicians, community members (e.g., a representative from the child advocacy center), resource parents, and ad hoc members. The results of the team meetings are then sent to continuous quality improvement teams for recommendations to the department.

FINDINGS

1. The department can improve investigation thoroughness

Finding

While some child safety investigations appear to be conducted thoroughly, others appear to be missing key documentation and may not be as thorough as possible. It is critical that child safety investigations are conducted in a timely and thorough manner because of the nature of the child abuse and neglect allegations that trigger a child safety investigation. Additionally, these investigations need to be consistently and completely documented in order to legally support and uphold the need to remove an at-risk child from his or her home and officially identify the perpetrator in state records (substantiation). In order to ensure that every investigation is thoroughly conducted and documented, the department should ensure caseworkers use the Tennessee Family and Child Tracking System (TFACTS) to consistently store key documentation, ensure supervisors follow up on identified investigation shortcomings, and overall improve caseworker consistency and supervision in conducting investigations. Additionally, the department has the opportunity to identify further ways to improve how it conducts investigations by analyzing the results of the case file reviews.

Child Safety Investigations Identify Abused and/or Neglected Children and Administratively Identify Perpetrators

The department's Child Safety Division follows up on allegations of child abuse and neglect received by the statewide Child Abuse Hotline. Specifically, regional investigators examine the child's living situation, such as the family, home, and alleged incident. Based on the investigation results, Child Safety investigators and their supervisors make two determinations. First, they decide whether a child has been abused or neglected. If so, and if the child is found to be in continuing danger, they can recommend that the child be removed from the family. A juvenile court must concur within 72 hours of the department removing a child from the home. Alternatively, if department investigators find that it is safe for the child to remain in the home, the department can provide supportive services, such as parental training. If the child has not been abused or neglected, the investigation is closed, although it is kept on file in case similar allegations are made in the future.

Secondly, if abuse or neglect occurred, the investigators and their supervisors decide whether a perpetrator can be identified. If so, then the identified perpetrator becomes a matter of record, which effectively bars the person from working in certain child-related fields, such as teaching, or from fostering or adopting children. Because children's welfares and potential

perpetrators' legal rights are at stake, it is critical that child safety investigations are conducted and documented consistently and thoroughly.

Investigations are Inconsistently Documented

Auditors conducted an in-depth review of electronic and paper documentation for 20 high-risk investigations from across the state, 10 of which were selected from approximately 936 substantiated cases reviewed by internal department reviewers from January 2012 to March 2013.[1] The other 10 cases were selected from the same substantiated cases reviewed but were from a specific region that an external stakeholder had reported to auditors was problematic. The region is not identified here because auditors did not find evidence that the region's investigations differed in quality from other regions. Because these are high-risk cases, the results should not be directly generalized to apply to the whole population. For example, the percent of cases within the sample that were not thoroughly investigated may not be the same as the percent of improperly investigated cases among all department cases. Rather, auditors were identifying commonalities among potentially problematic cases. However, all recommendations identified in this finding would still apply to the department in general.

Our review of 20 high-risk child safety investigation files from across the state found that while some investigations appear to be thoroughly documented and investigated, others lack documentation of key investigative steps and have other problems. All of the reviewed cases had been appealed and received for review by the end of calendar year 2012, so all of the documentation should have been present. Therefore, missing documentation can suggest, but not guarantee, that the missing information was never gathered.

First, we found that two cases were not investigated, documented, and/or supervised as thoroughly as needed. For example, one case was overturned because internal department reviewers noted that no interviews were conducted and the investigator only documented one case note. Similarly, another case was overturned because the investigators failed to clear up confusion over the exact identity and name of the perpetrator and because other key evidence was not documented.

These two cases also suggest that some supervisors are not as thorough as possible. For example, there was documentation in one case that the reviewing supervisor directed the investigator to obtain additional, specific information. However, there was no documentation in the file that the additional information had been obtained or that the supervisor ever followed up on the request prior to agreeing to close the case. The second case did not contain any narrative documentation that a supervisor review occurred. While 2 cases out of 20 may not ordinarily cause great concern, the nature of child abuse investigations is such that children's lives may be

[1] As explained on page 2, all audit work had to be conducted at a point in time, after which departmental changes may impact the process. Auditors selected this timeframe because it was the latest complete period for which the case reviews would have been completed at the time of the audit work. Auditors are unaware of any specific policy or practice changes that would directly impact the problems identified in this finding. However, the department is generally working to improve investigators' training and performance. It is possible that these efforts may improve the department's overall investigative performance, including remedying the problems identified here.

at stake. Therefore, it is vital that all cases be thoroughly investigated, documented, and supervised.

Critical Paper Documentation Maintained Outside of TFACTS

In addition to inconsistent investigations and oversight, some cases' key documentation was stored in paper form outside of TFACTS. Although TFACTS is the department's official record, TFACTS information was incomplete and we had to obtain additional documentation in order to thoroughly understand cases. For example, in one case, the electronic TFACTS file did not contain documentation of an important review process, a copy of the Immediate Protection Agreement (by which a parent agrees to take specific steps to protect the child), drug tests results, and a Child Protective Investigative Team (CPIT) review. This information was only available in paper form. Similarly, in a second case, only the paper file contained a safety assessment, the CPIT review, and background checks on the family member the child would be staying with.

One of TFACTS' roles is to provide a central repository so that information about every case can be safely stored, and retrieved from anywhere in the state when needed for legal proceedings, quality assurance, management oversight, investigation, and legislative reporting. If records are not kept in TFACTS, the department and other users cannot ensure they have a complete and accurate understanding of a case, and more importantly, a child's circumstance. Additionally, paper documentation is risky because it can be easily lost or misplaced. For example, one of the files the auditors requested could not be located, causing us to select a replacement case for review.

Child Safety managers stated that they are aware that documentation is not always consistently stored in TFACTS but that some of the documentation may be stored in paper form because of technical glitches in uploading and/or displaying the information, particularly photographs and lengthy autopsy reports. However, we noted documentation stored outside of TFACTS that did not fall into these categories. Additionally, many of the other cases contained the same type of externally stored documents, suggesting that the problem is not technical but rather that individual caseworkers are failing to enter information into TFACTS and their supervisors are failing to ensure they do so.

Additional Opportunity Exists to Identify Other Investigative Process Improvements

The department has an opportunity to further learn from and improve its investigation processes by analyzing appealed cases results. Alleged perpetrators have the opportunity to appeal substantiation decisions, first internally within the department, then to an administrative law judge. The result of each appeal is communicated to the involved field staff. However, no overall department-wide tracking or tabulation of results is conducted. This could present an additional opportunity for the department to learn where there are weaknesses in its investigation results and revise its policies, procedures, and training. Other states, including Arkansas and Missouri, conduct similar analyses and use results to make changes and improve investigations.

Recommendation

Department officials should ensure that all investigations are consistently and thoroughly conducted and documented and are subject to supervisory review in TFACTS, with paper storage reserved for only those isolated types of documentation that are currently problematic for TFACTS. The department should also continue to identify and address such TFACTS documentation storage problems and, as they are resolved, ensure case managers are notified that all future documentation should be maintained in TFACTS.

Results of internal case file reviews should be aggregated, tracked, and analyzed to identify recurring and current investigation weaknesses. This information should be used to improve training and policy and procedure updates.

Management's Comment

We concur. Thorough investigations and proper documentation are critical elements to protecting children and ensuring the risk of further abuse is reduced. The Office of Child Safety has embarked on a partnership with the Tennessee Bureau of Investigation (TBI) and created a CPS Investigator Training Academy that enhances many elements of the investigative process. Specifically related to this finding, the CPS Investigator Academy has courses on case file organization, documentation and presentation. There are courses related to drugs and a medical component taught by a certified child maltreatment pediatrician that directly addresses the medical evaluation and treatment of drug exposed children. This program has started, with the inaugural Academy class beginning the week of November 18th.

Additionally, the department is currently piloting tablet technology and various applications with the frontline staff to determine which technology will best support their daily activities, increase case efficiency and allow for more timely documentation. It is anticipated the pilot will be completed second quarter, CY2014. Further, the Office of Child Safety is in the planning stages of developing data dashboards that afford management and frontline staff the ability to track and monitor workflow and compliance in real time. The storage of information within the TFACTS system and organization of the case record are currently being addressed and a standardized system will be instituted. Finally, policies directly related to the child abuse hotline and investigative processes are currently under review by subject matter experts. Included in the overall review process is an opportunity for external partners to provide feedback about the policies, which we believe will improve investigative practice and strengthen relationships with partners.

2. The department can improve some Child Protective Investigative Teams' operations

Finding

The department works with local child advocacy centers to coordinate Child Protective Investigative Teams (CPITs or teams) who jointly conduct child sex abuse and severe child abuse investigations. However, these teams differ in their levels of attendance and how they operate. While some are well-attended, others struggle to ensure all required parties participate. Additionally, some teams function in a manner inconsistent with the teams' purpose. Finally, those teams coordinated primarily by department staff, because no center exists in the local area, are not required to conduct semi-annual self-evaluations, as are center-managed teams. In addition to addressing these differences, the department needs to use its new training, its statewide team advisory board, and its community relations analyst position to ensure all CPITs act consistently and effectively. The department also needs to continue to take steps to correct the computer interface between the centers and the department to ensure the centers are notified of all child abuse cases requiring team investigation.

CPITs Support Children and Investigations

Under Section 37-1-607, *Tennessee Code Annotated*, the department coordinates multi-disciplinary teams that investigate allegations of severe child abuse and child sexual abuse. Each of the state's 95 counties must have at least one team, consisting of, at a minimum, department staff, district attorney representatives, juvenile court representatives, and law enforcement officials. Under the department's policy, the teams' role "is to conduct child protective investigations and to support and provide services to severely abused and sexually abused children as deemed by the team to be necessary and appropriate."[2] In counties served by private child advocacy centers, the centers contract with the department to coordinate these teams. In counties not served by a center, other CPIT members, such as local department employees, coordinate the teams on an ongoing basis. In all jurisdictions, the team must convene immediately whenever a report of child sexual or severe physical abuse has been received. Typically, the department uses its computerized case management system, the Tennessee Family and Child Tracking System (TFACTS), to contact the centers' computer tracking system, NCAtrak, to notify the appropriate center of cases received within the last day that qualify for a team meeting. (NCAtrak is a database created for the National Children's Alliance to track and retrieve case information.)

CPITs Function Differently

Although investigative teams are important in reducing victim trauma while maximizing investigation quality, these teams differ in their functionality. For example, while some team coordinators report that all team participants regularly attend and participate in meetings, others report that some team members do not attend on a consistent basis. To obtain the opinions of professionals who work most closely with the teams, the auditors selected a non-scientific, but random, judgmental sample of coordinators from 15 of the state's 95 counties, including center

[2] Department of Children's Services Administrative and Policy Procedure 14.6: Child Protective Investigative Team (CPIT). Effective January 15, 2010.

and department employees. Of the 15 coordinators represented, 8 reported no current, consistent attendance problems. However, other team coordinators reported attendance problems, including the following:

- four team coordinators reported that juvenile court representatives did not consistently attend;
- three team coordinators reported that local law enforcement did not consistently attend; and
- two coordinators reported that department personnel did not consistently attend.

We contacted representatives of those groups with reported attendance problems to obtain their perspective. They reported a variety of reasons for their inconsistent attendance. Two groups had not been notified or invited to attend meetings. More commonly, team members reported that their team attendance conflicted with their other job responsibilities. For example, one youth court representative reported that he was the only youth resource officer for his entire county and frequently had to respond to other emergency calls. Likewise, a department supervisor reported that some case managers are not always able to attend because they are the only case manager responsible for an entire county.

In addition to struggling with attendance, some teams reportedly function in a way that is inconsistent with the teams' purpose. Specifically, although the teams are intended to help the investigative process, several team coordinators and team members reported that cases were often brought to CPIT after the department had concluded the investigation or were presented in a way that suggested a conclusion had been pre-determined and meaningful discussion was not to occur. In this situation, the team may serve more as an administrative sign-off necessary for the department to close the case, rather than a meaningful method of improving investigation quality and minimizing victim trauma. For example, one team coordinator reported that the department and law enforcement usually conclude an investigation before presenting the case to the team, and some cases are even closed before being presented to the team. Another reported that case managers appear at meetings unprepared and view CPIT meetings as the final step before closing the case.

Those teams coordinated primarily by department employees (because no center exists) function differently than center-managed teams, in that they are not required to conduct semi-annual and other surveys of their members. According to research sponsored by the U.S. Department of Justice, one of the keys to a successful team operation includes periodic self-analysis and outside evaluation of the team. As a result, all centers that coordinate team meetings under a grant contract with the department are required to conduct semi-annual surveys of team members regarding general team operations and periodic case-specific surveys of team members. The results of these surveys are submitted to the department. If they reveal any significant team problems, or if problems otherwise become apparent, the center is required to contact the department for assistance. However, teams primarily coordinated by department personnel (because there is no center to contract with) are not required to complete the same or similar survey assessments. As a result, the department may be missing an opportunity to identify and correct team functioning problems. The Tennessee Chapter of Children's Advocacy

Centers reports that they are willing to provide training to department team coordinators on conducting the surveys.

Department Developing New Methods to Improve CPITs

The department reports that its new caseworker training will include information on the team process. This training would provide an opportunity to re-enforce the proper use and importance of the CPIT process, including that cases should be brought to the teams for active discussion during the investigation process, not after the investigation has been concluded. The department is also in the process of developing two mechanisms with the potential to improve CPIT consistency and effectiveness. First, the department has created a new statewide community relations analyst position, whose responsibilities include identifying gaps in team coverage and operations. The official hired for the new position reports that her first month's goal is to assess team operations across the state to identify what works well and what presents challenges. Secondly, the department is creating a new statewide CPIT advisory board. Both of these tools have the potential to improve team operations and should be used to ensure that teams act consistently and effectively.

Problems With Computer Interface Exist Between Department and Child Advocacy Centers

The computer interface between the department and child advocacy centers does not operate optimally. The department notifies child advocacy centers of child sex abuse and severe child abuse cases qualifying for CPIT meetings through a computerized link between TFACTS and the centers' computer system, NCAtrak. Once per day, TFACTS sends NCAtrak information about all the qualifying cases received through the Child Abuse Hotline the day before.

Despite its importance, this interface between TFACTS and NCAtrak has experienced numerous problems. First, TFACTS only provides information to NCAtrak about cases once and does not update this information even if the case no longer requires or qualifies for a team meeting. Case statuses could change for a variety of reasons. For example, the initial investigation could reveal that the abuse was not as severe as suspected when the case was first received or that the abuse occurred elsewhere and the case needs to be transferred to another region and team. When centers are not notified that cases no longer require team involvement, the cases may remain on the team's dockets for an extended period of time awaiting department presentations that will never occur, or centers may get the impression that the department is losing or purposely ignoring cases, as was reported to auditors during interviews.

In addition to the long-standing problem of only providing one-time information, the interface also encountered several problems in 2013. First, the department allowed its security certificate, which is necessary to send information to NCAtrak, to expire around the end of July 2013. As a result, TFACTS did not refer any cases to NCAtrak. The department only became aware of the problem when some centers reported in August that they had not received any referrals in some time. Regional department staff had to fax or hand-deliver referrals to the centers until the department fixed the security certificate problem in mid-August 2013.

In addition, some cases that should have been automatically referred have not been referred. As of late August 2013, the department was still working to identify the cause. After the security certificate problem was fixed, the department asked centers to identify any cases they believe should have been automatically referred through the computer interface but were not. The department reports receiving 5 to 10 examples of such cases and is researching to determine whether the cases should have been referred and, if so, why they were not.

These challenges underscore the importance of reconciling the referrals received by the Child Abuse Hotline that qualify and require a team meeting with the cases received by the appropriate centers, whether by computerized interface, manual fax, or hand delivery. However, the department currently does not perform this reconciliation, which is needed to ensure severe child abuse and sexual abuse cases are subject to the critical team process.

Recommendation

The department should insist that all CPITs act in a consistent and effective manner by ensuring all team coordinators send invitations or notices to all team members about all events and by ensuring all department caseworkers bring cases to the teams during the active investigation phase rather than using teams as a simple check-off. Teams coordinated by non-center personnel should conduct the same surveys/self-evaluations conducted by child advocacy centers. Additionally, the department should use its new case manager training, statewide CPIT advisory board, and community relations analyst to reinforce the intended purpose and use of CPITs, as well as to encourage attendance from all statutorily required team members.

The department also should improve communications with the CPITs by developing methods to update teams operated by child advocacy centers about cases no longer requiring a CPIT meeting, such as updating NCAtrak; ensuring that the department's security certificate remains current; and continuing to work to fix the problem that may have resulted in some potentially qualifying cases not automatically referring to centers. The department should also develop a process to reconcile cases received by the Child Abuse Hotline that qualify for the CPIT process with the cases received by the teams.

Management's Comment

We concur. The Office of Child Safety has created a Division of Community Partnerships. The Director of Community Partnerships serves as the statewide CPIT Coordinator and is tasked with building partnerships and improving the consistency among the CPITs statewide. The functioning of individual CPITs is being evaluated through face to face meetings and discussions with various members of CPIT. As concerns and issues are identified, the Director of Community Partnerships works with the Tennessee Chapter of Child Advocacy Centers to facilitate discussions that lead to better collaboration and ultimately more uniformity among CPITs statewide. The Office of Child Safety has created a statewide CPIT Advisory Board charter. The department is in the process of identifying board representation. The department has no authority over CPIT partners, such as juvenile court representatives and law

enforcement, to mandate their attendance in CPIT meetings. Rather, it is the intention of the department through the creation of the CPIT Advisory Board that other partners will assist in facilitating a more uniform approach to the CPIT process with their respective peers.

The Director of Community Partnerships was made aware of the NCATrak issues and once informed, immediately began to identify the problem and work towards a resolution. She also communicated regularly with the CACs to keep them informed of the problems and worked with the regional CPS supervisors to ensure information was shared with the CACs while the NCATrak issues were being addressed. After the issues were resolved, a data report was provided to the CACs to ensure cases were accurately captured in NCATrak and information was not lost.

There is one judicial district that does not have a CAC and the Director of Community Partnerships and the Executive Director of the TN Chapter of Children's Advocacy Centers are discussing the need for one with the community partners. Efforts in the past to establish a center in that district have been unsuccessful. The TN Chapter administers CPIT surveys quarterly to the CACs as a requirement of their contract. The department will explore including a survey to the CPIT teams within the judicial district without a CAC.

TCA 37-1-607 states the department shall coordinate the services of child protective teams. The oversight of this function is handled by the child advocacy centers, which receive funding through a contract with DCS. In this role, the CACs receive information directly from TFACTS to the NCAtrak and they are responsible for ensuring CPIT meetings are scheduled, team members are notified of the meeting dates, preparing the agendas with identified cases to be discussed and data collection.

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3. The department needs to better track child abuse and neglect referrals faxed in to the Child Abuse Hotline

Finding

While the Child Abuse Hotline appears to handle most referrals received by fax or internet in a timely and appropriate manner, there are discrepancies in some cases' tracking documentation that need to be addressed. The department receives the overwhelming majority of child abuse and neglect referrals by telephone, but some referrals are received by fax, internet, or mail. These referrals are tracked by a combination of manual and computerized logs and documentation. Auditors tested 60 referrals received through methods other than telephone in December 2012 and March 2013 and found that the majority (52) were processed in a timely and appropriate manner. However, auditors could not properly assess the remaining referrals because of discrepancies in their tracking records. While these discrepancies could be attributed to simple human errors, the department cannot absolutely ensure these referrals were handled in a timely or appropriate manner. Because these referrals potentially involve children at high risk,

the department needs to improve how it tracks fax and internet referrals to minimize discrepancies.

Child Abuse Hotline Screens Child Abuse and Neglect Reports

The Department of Children's Services established the Child Abuse Hotline (formerly known as Central Intake) to serve as a central reporting center for allegations of child abuse and neglect in Tennessee. Operating under guidelines established by Administrative Policy 14.1, the Child Abuse Hotline is staffed with case managers who are available to take reports of abuse and/or neglect 24 hours a day, 7 days a week. While the majority of reports are received by telephone, Section (A)(c) of Policy 14.1 allows reports to also be received by email, fax, in writing, or in person.

Fax, internet, and mail referrals are each handled somewhat differently. At the time of this audit, the Tennessee Family and Child Tracking System (TFACTS) sent referrals received through the department's webpage to a designated hotline email box. Hotline supervisors monitored the email box and emailed the referrals to their hotline case managers for recording and screening.[3] In contrast, a combination of hotline administrative personnel and case managers receive hotline fax referrals and date stamp, number, and record faxed referrals on an Excel spreadsheet for tracking, then provide the faxes to case management staff for recording and screening. Very few referrals are received by mail, but they are handled in the same manner as faxed referrals. Department supervisors expect that referrals received via fax, email, or in writing should be completed (properly entered into TFACTS or screened out) by the end of the shift during which they are received.

For fiscal year 2013, the department reports that the hotline received over 107,000 reports, of which the overwhelming majority (over 99,000, or approximately 93%) were received by telephone. The next largest groups were received by internet (over 5,000, or almost 5%) and fax (over 2,200, or approximately 2%). The remaining cases, which totaled less than 300, were received by email, overnight express, in-person, inter-office mail, or U.S. mail.

Majority of Fax and Internet Referrals Handled Timely and Appropriately, However Discrepancies Exist in Tracking Some Referrals

The hotline appears to handle the majority of internet and fax referrals in a timely and appropriate manner. Auditors examined a total of 60 files received via fax or email—30 from December 2012 and 30 from March 2013.[4] Hotline staff processed 52 of the 60 fax and internet referrals within 24 hours and in an appropriate manner. Several referrals reviewed had unexplainable record discrepancies that made assessment of handling quality impossible. Specifically, 8 of the 60 fax and internet referrals' tracking documentation showed these referrals were entered into TFACTS before they were recorded in the Excel spreadsheet, which is inconsistent with the process in place at the time of the audit and raises questions about how they were handled (as described above). The differences between the manual spreadsheet receipt date and the TFACTS entry date were between 1 day and 23 days. Six of the eight discrepancies are

[3] Hotline staff report that all web referrals will be routed through the telephone system queue in the future.
[4] Department records show that no referrals were received by mail in December 2012 and March 2013.

associated with December 2012 referrals, while only two are associated with March 2013 referrals.

Auditors were unable to review hard-copy original records for these eight files because documentation is only maintained for two months. Although we were unable to conclude how these referrals were handled, auditors identified several possible explanations for the discrepancies. First, hotline staff may have mistyped spreadsheet tracking log entries. Second, hotline staff may have reversed the handling order so that the record of receipt was entered after TFACTS processing. This would bring the integrity of the receipt records into question because it would suggest that some fax, internet, and mail referrals are not being promptly entered into the manual receipt tracking spreadsheet. Third, it is possible that these eight referrals were otherwise inappropriately received or handled. Because these referrals involve potentially abused and neglected children, they represent a high risk and need to be addressed.

Recommendation

The department needs to improve its tracking of child abuse and neglect referrals received by internet, fax, and mail so that discrepancies are detected, analyzed, and addressed. Specifically, the department could consider providing additional training to hotline staff on the fax, internet, and mail referral handling process, including the importance of correctly entering receipt dates into the manual tracking spreadsheet. The department could also institute a regular, frequently scheduled reconciliation between the manual tracking spreadsheet and TFACTS to identify any potential handling problems for follow-up.

Management's Comment

We concur. The department has been working with OIT and Presidio to improve the capability to receive web referrals. A new system is being developed that will automatically populate information into TFACTS, thus eliminating the need to manually enter information into TFACTS.

A report that tracks all types of referrals through TFACTS has been developed and will be in production soon. In the meantime, a person monitors faxes daily. Faxes are date stamped and entered into a computer log. The fax is then assigned to a call agent and when the information is entered into TFACTS, the log is updated and the fax is filed in a central location. The log is checked daily to ensure all faxes are completed.

4. The department has not complied with all legislative reporting requirements

Finding

The department did not report all statutorily required information to the General Assembly during fiscal years 2011-2013. For example, the department did not report the deaths of children in its custody to the child's legislators as required by Section 37-5-124, *Tennessee Code Annotated*, until this requirement was publicized in a high-profile media report in late 2012. (Additional unmet requirements are detailed below.) However, the department did provide other statutorily required reports. For example, the department appears to be complying with Section 37-5-129, *Tennessee Code Annotated*, which requires it to submit any new departmental policies within 60 days of adoption to the Judiciary Committee of the Senate and the Civil Justice Committee of the House of Representatives. Some provisions in statute are no longer relevant, and the General Assembly may wish to consider eliminating them and clarifying others, especially those related to the department's 2009 implementation of the multi-level response system.

Some Legislative Reporting Requirements Unmet

The department failed to report the following statutorily required information to the General Assembly during fiscal years 2011-2013.

- The department did not comply with Section 37-2-205(f)(3), *Tennessee Code Annotated*, in that it did not submit a report to the Senate Judiciary Committee and the House Civil Justice Committee on county commitment data for the previous calendar year and a description of any steps taken as part of a collaborative planning process with the juvenile courts regarding juvenile detention in county facilities.
- The department did not comply with Section 37-3-501(e), *Tennessee Code Annotated*, which requires it to work with the Department of Health and other departments that administer services to children and families to jointly report, at least annually and on or before December 31, to the Senate Judiciary Committee and the House Civil Justice Committee concerning administration of the Tennessee informational clearinghouse on teenage pregnancy. Department of Health staff reported major funding and program changes related to the clearinghouse. If the Department of Health, the Department of Children's Services, and other impacted state agencies would like to suspend the clearinghouse's operations and the associated reporting requirement, they should propose legislation either eliminating or amending clearinghouse operations and the resulting reporting.
- The department did not fully comply with Section 37-3-604, *Tennessee Code Annotated*, by annually reporting, on before December 31 of each year, all specified information about the family preservation and support services to the Governor; the chairs of the Senate Health and Welfare and Judiciary Committees; and the chair of the House Civil Justice Committee. The department only reported the number of children in foster care, which is one of several report elements required by the statute.

- The department did not fully comply with Section 37-5-105(4), *Tennessee Code Annotated*. While the department produces an annual report with some statutorily required elements, other required elements have not been included. For example, the report covering fiscal year 2012, published in January 2013, did not include the available number of Children's Services foster care placements, the social services case manager average salary by region, the average social services caseload by region, and the range of social services caseloads by region.

- The department admits that it failed to comply with Section 37-5-124, *Tennessee Code Annotated*, which requires the department to report certain child deaths and near deaths within 10 days to the Senate and House representatives for the child's legislative district. In response to media attention to the requirement in September 2012, the department developed a process to provide this information.

- The department did not comply with Section 37-5-128, *Tennessee Code Annotated*, which requires it to appear before the Senate Judiciary Committee and the House Civil Justice Committee by March 1 of each year for a review of departmental policies and protocols. The department reports that it submits policy and protocol changes to the committee chairs, but the committees did not invite the department to appear in either 2012 or 2013. However, the statute does not indicate that the department must wait for an invitation. The burden is on the department to request the appearance. Therefore, the department should request to appear before the Senate Judiciary Committee and the House Civil Justice Committee by March 1 of each year for a review of department policies and protocols.

Additionally, the department provided an updated comprehensive state plan regarding child sexual abuse to the General Assembly by January 31, 2011, and January 31, 2013, as required by Sections 37-1-603(a), (b)(1)(B), and (c)(2), *Tennessee Code Annotated*. However, part (a) also requires that specific parties be given the opportunity to participate in the plan's development. One required group, local school boards, are only indirectly represented on the task force that developed the plan. While no local school board representatives sit on the task force, representatives of citizen review panels, whose membership includes local school board representatives, do sit on the task force. Additionally, the task force does not include any childcare center representatives or otherwise provide an opportunity for this group to participate in the plan's development.

Finally, while the department technically complied with Section 37-5-519, *Tennessee Code Annotated*, in that it reported information about the status of childcare agencies within the state subject to its jurisdiction, the method it used to accomplish this compliance was questionable. The department typically reports childcare agencies' information as part of its annual report. However, the information was not included when the annual report for fiscal year 2012 was published and provided to the General Assembly in January 2013. In response to auditors' inquiries, the department added the childcare agencies' information to the annual report and reposted the annual report on its website in August 2013. However, the revised annual report was not labeled as such, nor did it include any disclosure that it had been revised. Similarly, the website did not indicate that the annual report had been revised, and parties who had received the original annual report (including the General Assembly) were not notified of the

revision. Statute requires the report be published "for the information of the General Assembly and for distribution to interested parties." The department may have technically complied with Section 37-5-519, but it did so in a way that was not as transparent as possible.

Statutory Changes Needed

The statutes also contain other legislative reporting requirements that are no longer applicable. At least three statutes create reporting requirements tied to the department's pilot implementation of the multi-level response system. The system was implemented statewide in spring 2009, and is no longer a pilot program. The three statutes are as follows:

- Section 37-5-603(b), *Tennessee Code Annotated*, required the department to report on its progress on implementation of the multi-level response system until the system was fully implemented statewide. Because statewide implementation is complete, the department is no longer required to report this information.
- Section 37-5-605, *Tennessee Code Annotated*, required the department to report the outcomes of its multi-level response system demonstration project until the system was fully implemented statewide. As noted above, statewide implementation is complete; therefore, the department is no longer required to report this information.
- Section 37-1-406(m)(1)(g)(2), *Tennessee Code Annotated*, required the department to compile and present to the Senate Judiciary Committee and House Civil Justice Committee reports made by local law enforcement agencies or district attorneys when they decide not to proceed with or terminate child abuse and neglect prosecutions. This information was to be part of the department's multi-level response system report, however, as previously discussed, the department is no longer statutorily obligated to produce the multi-response system report.

Because these reporting requirements are no longer applicable, the General Assembly may wish to consider removing these requirements in order to minimize unnecessary statutory language and reduce the potential for confusion. Alternatively, if the General Assembly wishes to continue to receive information regarding the multi-level response system, the statutes could be updated to require the provision of information on the fully implemented system.

Recommendation

The department should comply with mandates to provide information to the General Assembly, in accordance with the statutory sections below.

- Section 37-2-205(f)(3), *Tennessee Code Annotated*, by providing a report to the Senate Judiciary Committee and the House Civil Justice Committee on county commitment data for the previous calendar year and a description of steps taken as part of a collaborative planning process regarding juvenile detention in county facilities.

- Section 37-3-501(e), *Tennessee Code Annotated*, by working with the Department of Health and other departments that administer services to children and families to jointly report, at least annually, on or before December 31, to the Senate Judiciary Committee and the House Civil Justice Committee concerning administration of the Tennessee informational clearinghouse on teenage pregnancy. Alternatively, if the department, the Department of Health, and other impacted state agencies would like to suspend the clearinghouse's operations and this associated reporting requirement, they should propose legislation either eliminating or amending clearinghouse operations and the resulting reporting.
- Section 37-3-604, *Tennessee Code Annotated*, by annually reporting, on or before December 31 of each year, all specified information about the family preservation and support services to the Governor; the chairs of the Senate Health and Welfare and Judiciary Committees; and the chair of the House Civil Justice Committee.
- Section 37-5-105(4), *Tennessee Code Annotated*, by annually reporting all required elements in its annual report to all members of the General Assembly and specified other parties by January 31 of every year.
- Section 37-5-124, *Tennessee Code Annotated*, by continuing to report statutorily specified child deaths and near deaths within 10 days to the senator and representative for the child's legislative district.
- Section 37-5-128, *Tennessee Code Annotated*, by requesting to appear before the Senate Judiciary Committee and the House Civil Justice Committee by March 1 of each year for a review of departmental policies and protocols. Alternatively, the General Assembly may wish to consider amending this statute to remove the reporting requirement.
- Sections 37-1-603(a), (b)(1)(B), and (c)(2), *Tennessee Code Annotated*, by providing a direct opportunity for childcare centers and local school boards to participate in the development of a comprehensive state plan regarding child sexual abuse.

Additionally, if the department reissues its annual report or other similar reports, as it did to comply with Section 37-5-519, *Tennessee Code Annotated*, it should notify all parties who received the original report, as well as clearly note in the report and on the department's website, that the report has been revised.

The General Assembly may wish to consider deleting or amending statutory reporting requirements associated with the multi-level response system prior to completion of statewide implementation, including Sections 37-1-406(m)(1)(g)(2), 37-5-603(b), and 37-5-605, *Tennessee Code Annotated*.

Management's Comment

37-2-205(f)(3)

We concur. The department has put into place a new procedure for ensuring compliance with statutory reporting and has identified an individual in the department's central office who will

monitor completion and be responsible for delivery of reports to the legislature. The identified individual will also confirm that the reports' contents contain all information required by the directing statute.

37-3-501
We concur. While the funding and operations of the clearinghouse have significantly changed, the department did not issue a report to the legislature stating this change. The department will, moving forward, issue a report to the legislature annually with this information.

37-3-604
We concur. The department has put into place a new procedure for ensuring compliance with statutory reporting and has identified an individual in the department's central office who will monitor completion and be responsible for delivery of reports to the legislature. The identified individual will also confirm that the reports' contents contain all information required by the directing statute.

37-5-105
We concur. The department has put into place a new procedure for ensuring compliance with statutory reporting and has identified an individual in the department's central office who will monitor completion and be responsible for delivery of reports to the legislature. The identified individual will also confirm that the reports' contents contain all information required by the directing statute.

37-5-124
We concur. The department previously did not comply with the statute requiring the reporting of deaths and near-deaths to members of the General Assembly. In September 2012, the department instituted a new procedure for creating and delivering these notifications. The department continues to meet this requirement.

37-5-128
We concur. The department has not appeared before the Senate Judiciary and House Civil Justice Committees in previous years to review departmental policy and protocols. In deference to the General Assembly, the department has traditionally waited for an invitation before appearing or seeking to appear before any legislative committee. The department will request an invitation for a hearing before both committees if the chairs of each committee deem the request appropriate.

37-1-603
We concur. The department has put into place a new procedure for ensuring compliance with statutory reporting and has identified an individual in the department's central office who will monitor completion and be responsible for delivery of reports to the legislature. The identified individual will also confirm that the reports' contents contain all information required by the statute.

37-5-519
We concur. The department has put into place a new procedure for ensuring compliance with statutory reporting and has identified an individual in the department's central office who will monitor completion and be responsible for delivery of reports to the legislature. The identified individual will also confirm that the reports' contents contain all information required by the statute.

In the summer of 2013, the department's legal staff, along with the department's legislative staff, conducted an in-depth review of relevant statutes to determine the reporting requirements of the department. As a result of this review, a central document containing report contents, responsible program area, delivery methods, audience, and due date was created. In addition to the creation of the document, the individual responsible for ensuring compliance with the reporting requirements has begun to meet with program staff responsible for gathering data and generating the reports.

OBSERVATIONS AND COMMENTS

The topics discussed below did not warrant a finding but are included in this report because of their effect on the operations of the department and on the citizens of Tennessee.

The Department Should Consider Supplementing Its Existing Policy Regarding Methamphetamine-Exposed Children, to Include More Detail on Long-Term Medical Needs, As Well As Ensuring Pediatricians Who May Treat Such Children Are Familiar With Appropriate Medical Protocols

The department has the opportunity to further improve its existing mandatory policies addressing methamphetamine (meth) exposed children and ensure the medical community is aware of the policies. The department's current mandatory policy focuses on meth-exposed children's short-term medical needs, while mentioning their long-term needs in broad, undetailed language. In addition, the department has prepared suggested (but not mandatory) protocols which provide much more detailed direction and focus on the children's long-term medical and developmental needs. Regardless of whether the department opts to improve its existing mandatory policies, it needs to ensure that the medical doctors who may encounter such children are aware of department policies and/or appropriate, detailed medical protocols for identifying and treating meth-exposed children's short- and long-term needs.

According to the Government Accountability Office, for the 10-year period from 2002 to 2011, Tennessee ranked second highest among the 50 states and the District of Columbia for the number of meth lab incidents. According to the United States Department of Justice, the short-term and long-term dangers to children living in meth laboratories are numerous:

> The chemicals used to cook meth and the toxic compounds and byproducts resulting from its [methamphetamine's] manufacture produce toxic fumes, vapors, and spills….Chronic exposure to the chemicals typically used in meth manufacture may cause cancer; damage the brain, liver, kidney, spleen, and immunologic system; and result in birth defects….Children living at meth lab sites may experience the added trauma of witnessing violence, being forced to participate in

violence, caring for an incapacitated or injured sibling, or watching the police arrest and remove a parent.[5]

The department already has a mandatory policy in place addressing how investigative caseworkers respond to and deal with children who have been placed in such dangerous situations. The portions of the policy focusing on such children's medical needs are basic and primarily address the children's immediate medical needs, while acknowledging that long-term care is important and required. This same policy goes on to provide much more detailed, but only suggested (not mandatory), medical protocol focusing on the children's long-term developmental and medical needs.

Additionally, we found that the mandatory policy and suggested protocols may not be well known among medical professionals likely to serve such children. For example, one of the state's most well-known pediatric physicians active with the department reported to auditors that a policy was badly needed to ensure that exposed children receive at least a minimal level of long-term medical follow-up, but was not aware that the department already had a policy and protocols. Likewise, the spring 2006 issue of *Vanderbilt Medicine* stated that Tennessee hospitals lack a statewide, consistent protocol for dealing with children exposed to meth.

According to department staff, the medical portion of the meth-exposed children policy is not mandatory because "all the players and pieces" were not in place when the protocol was created. Additionally, the department wants medical professionals to be free to exercise their medical judgment when dealing with department-referred children. However, given that not all medical professionals who treat such children are aware of the policy, that some medical professionals may infrequently treat meth-exposed children, and that Tennessee hospital facilities do not have consistent protocols for such children, the department should examine whether its current mandatory guidance could be expanded and more detailed, especially as it relates to children's long-term developmental and medical needs. Regardless, the department should ensure that medical professionals likely to treat meth-exposed children are familiar with the department's protocol to address children's short- and long-term needs.

The Tennessee Child Abuse Hotline Continues to Make Progress in Improving Call Wait Times and Lowering Call Abandonment Rates

The Tennessee Child Abuse Hotline has made progress in improving call wait times and lowering the call abandonment rate. In the fall of 2012, the Department of Children's Services became aware that the Child Abuse Hotline (then known as Central Intake) was not adequately meeting the daily demands of an effective call center. At that time, managers perceived that hotline callers were experiencing long wait times, with many callers hanging up before speaking with a case manager. The large volume of hang-ups resulted in a high call abandonment rate—a statistic tracked by the Child Abuse Hotline as a measure of call center efficiency and

[5] United States Department of Justice, Office of Justice Programs, Office for Victims of Crime, OVC Bulletin, June 2003. The bulletin further cites this information as based on the work of Sabine M. Oishi, Kathleen M. West, and Shelby Stuntz in the "Drug Endangered Children Health and Safety Manual" published in May 2000 by the Drug Endangered Children Resource Center of Los Angeles, California.

effectiveness. Department management acknowledged that the Child Abuse Hotline needed to address lagging performance, improve its processes, and implement sustainable changes to ensure the call center could operate in an efficient and effective manner going forward. For example, the department set internal goals for the call center, including an acceptable maximum amount of time that callers should wait before speaking with a case manager.

Auditors' review of the Child Abuse Hotline began in May 2013, by which time significant changes had been made, including the appointment of a new director. Department management also reported a decrease in call wait times and the call abandonment rate, operating within the acceptable range of 2%–4% (down from 20% in October 2012). Auditors' work focused on documenting and assessing strategies being developed and implemented, and reviewing available call center data.

Changes Made in Call Center Operations

To improve call center operations, the department addressed the quality of staff working in the call center. Beginning in November 2012, management began giving preference to applicants with prior Child Protective Services field experience or those with a degree in social work. Because of the importance of accurately and efficiently entering intake data into the department's case management computer system (imperative for both speed of operation and effective case tracking), applicants were also required to take a typing test. Several applicants were reportedly passed over because their typing skills were unacceptable.

In addition to filling vacant positions with more qualified case managers, current call center employees participated in mandatory training classes designed to improve their skills. Monthly team meetings were also implemented to keep case managers updated on call center changes. For example, at a meeting held in December 2012, call center management told staff that significant changes were happening at the call center and that they needed to "put their best foot forward and do the best job possible for the children of the State of Tennessee." These changes included adapting to working in a more data-driven call center environment, with an increased focus on personal responsibility and evaluation of individual performance. Team meetings also focused on developing a well-trained staff of case managers with the appropriate skills to work more efficiently while making fewer mistakes.

In conjunction with improving the efficiency and effectiveness of the case managers responsible for taking incoming referrals of child abuse and neglect, the hotline also implemented technological changes to improve daily operations. For example, call center management shortened the length of the initial automated voice recording that callers heard at the beginning of every call. In October 2012, this automated voice recording lasted approximately 1.5 minutes and included 15 seconds of silence. By December 2012, the length of the message had been reduced to approximately 20 seconds, allowing callers to reach a case manager more quickly.

Additional changes to call center functions have included prioritizing calls from educators, medical professionals, and law enforcement, and staffing these prioritized lines with

the most efficient case managers. According to department personnel, these changes have resulted in shorter wait times and fewer abandoned calls.

Staffing Levels Analyzed

A review of call center operations by the Governor's Call Center Improvement Team in late 2012 recommended that the Child Abuse Hotline hire a data analyst. This person's primary responsibilities would include monitoring and reporting on staffing needs (based on call volume), as well as providing management with accurate call center data when requested. As of June 2013, the Child Abuse Hotline had a full-time analyst on staff.

The chart below details hotline staffing levels as of October 2013.

Tennessee Child Abuse Hotline Staffing Levels
October 2013

Position	Filled	Vacant	Total
Case Manager 1 and 2	49	2	51
Case Manager 3	8	1	9
Case Manager 4 (Team Leader)	7	0	7
Training Coordinator	1	0	1
Director	1	0	1
Business Analyst	1	0	1
On-the-Job Trainer	1	0	1
Administrative Services Assistant 2	1	0	1
Secretary	1	0	1
Part-Time	3	2	5
Total	**73**	**5**	**78**

Call center management receives call center data reports on a daily and weekly basis. According to call center staff, daily performance reports are vital because they provide real-time feedback on the hotline's performance, including overall call volume, percentage of abandoned calls, and percentage of calls abandoned in less than 20 seconds. The reports also include information such as longest hold time, hold times over 5 minutes, and a list of abandoned calls. Staff explained that, although it is not necessary to look at every call, the daily report information helps them identify problems (system/phone issues, staffing issues, or personnel issues) and address those issues quickly. The aggregated daily data can also be used to track seasonal fluctuations in call volume and provide a historical perspective on the hotline's operations. This information can help management set better staff schedules and improve staffing patterns for the hotline.

Performance Improving

Beginning in March 2013, weekly call center reports have been provided to the Commissioner of the Department of Children's Services and other key stakeholders. An unaudited report sent to the Commissioner on October 7, 2013, indicated that in a "year-over-year" comparison for the week of September 29, 2013 with the same week in 2012, the number

of calls handled increased by 194 (up 6.9%), and the number of calls abandoned decreased by 249 (down 65.7%).[6]

Appendix 4 shows unaudited call-handling information for January through September 2013, such as the average speed to answer calls and the number of calls on hold for over five minutes. During that nine-month period, incoming calls were answered within an average of 24 seconds. Appendix 5 shows the unaudited weekly "week-over-week" comparison data from January through September of calendar years 2012 and 2013.

The Department Faces Challenges in Lowering Investigators' Caseloads

Although the department hopes to lower its investigators' average caseloads, this will be difficult to achieve. At the time of audit fieldwork, the department had an unwritten protocol of assigning no more than 11 new cases to each full-time investigator each month. A case refers to a single family that has been reported to the department, which may include multiple children. The department's goal is to lower that standard to no more than eight new cases per month. This is reasonable when compared with national accreditation standards; however, the department faces several challenges to realize this goal. Specifically, some regions do not always meet the unofficial 11 new cases per month maximum. Additionally, the department lacks a reliable Tennessee Family and Child Tracking System (TFACTS) report to help in case assignment decisions. Finally, despite its efforts, the department's ability to reduce caseloads is heavily driven by the number of child abuse and neglect reports it receives, which is outside of its control. Therefore, as the department reorganizes its investigators, it should closely monitor caseloads and make adjustments as needed to meet its goals.

Caseloads Ideally Limited to Enhance Investigation Quality

Because Child Protective Services' investigations potentially address serious life and death incidents involving alleged abuse or neglect of children, cases need to be thoroughly investigated, documented, and overseen. Because of the large amount of work and time required for each case, investigation case managers ideally should be limited in the number of investigation cases that they are assigned. We found the department operating under an unofficial and unwritten protocol that prohibits investigation case managers from receiving more than 11 new cases each month, with the goal of lowering that standard to no more than 8 new cases to each investigator per month.

[6] These and all other figures in this finding are unaudited. Auditors were unable to audit and/or independently verify these figures for several reasons. First, this system is new to the state, and not enough time has elapsed to identify any systematic problems. Second, because of the nature of call center operations, dozens of staff members could be simultaneously answering telephone calls, and it would be virtually impossible to independently monitor calls and then ensure they are recorded accurately by the software. However, we did interview key users of the telephone system data reports, who stated they are comfortable that the software produces reliable reports. Additionally, we verified multiple mathematical calculations produced by the software and found they were correct. While this data has not been audited, we believe that it represents the best data available and that we took appropriate steps to evaluate the validity and reliability of data used to support critical audit findings.

While the department's informal caseload policy focuses on new, incoming cases, it does not address existing cases within the department's caseload. However, the department's investigation policies require that investigators finish and close cases within 60 days (though cases can be transferred to family service workers for ongoing services beyond that 60-day period). This policy effectively limits investigative caseworkers' ongoing cases, allowing caseload policies to focus on new case assignments. Within the 60-day limit, caseworkers are expected to obtain all relevant evidence to conclude whether abuse or neglect occurred and who perpetrated the abuse or neglect. Caseworkers obtain medical records; research the family's legal and department history; and interview the victim, other children in the family, caregivers, teachers, the alleged perpetrator, and the parents.

Caseload Protocol Consistent With National Standards

Both the department's current and long-term limits are consistent with national standards. The Child Welfare League of America's Council on Accreditation, which publishes national accreditations for child welfare organizations, recommends that case managers be assigned no more than 12 new cases each month. Although the national standard is higher than the department's caseload protocol, the ideal caseload standard would be based on the organization's unique workload needs.

Department Faces Challenges to Lower Caseloads

While the department's goal of lowering caseloads has the potential to improve investigation quality, meeting this goal will not be easy. Some regions do not always meet the unofficial 11 new cases per month maximum. For example, auditors reviewed 6 judgmentally selected regional offices' investigation and assessment caseload assignment processes and records for one month,[7] and found that of 6 regions tested, 4 had caseworkers assigned more than 11 cases in the tested month, with some caseworkers receiving as many as 15 new cases per month.

Department officials reported that some caseworkers received more than 11 new cases in a single month for a variety of reasons. For example, one caseworker was absent from work the prior month. However, nothing in the protocol allows for exceeding the caseload in the current month because of time off work the prior month. Other supervisors reported that the caseload limits were exceeded because the region experienced an increase in the number of new cases.

At the time of our audit work, the department lacked a reliable TFACTS report to assist with case assignment and staffing decisions. In the past, TFACTS was able to generate a caseload report documenting which case manager was assigned to each case; however, department management reported that, because of technical issues, the report was unable to correctly identify which case manager was assigned to a case, so the TFACTS caseload report was discontinued. While management determines the extent of technical issues, the department is taking steps to identify and correct those issues so TFACTS can generate the report again. The

[7] Auditors reviewed the Davidson region's December 2012 case assignment records and the Shelby region's May 2013 case assignment records, as well as the Upper Cumberland, Northwest, Knox, and Smoky Mountain regions' July 2013 case assignment records.

TFACTS caseload report will help upper management allocate resources (case managers) within the regions. Additionally, this report will likely be helpful for staff responsible for assigning cases to case managers within the caseload limits. Without the report, caseload assignment is done by regional staff based on manually maintained electronic spreadsheets, which in turn must be individually submitted to the central office for monitoring of caseload levels.

Department Reorganizing and Training Investigators

As of October 2013, the department is in the process of reorganizing its investigative staff and designing new investigative training, which should significantly impact caseloads. Specifically, management is upgrading case manager investigation positions; reassessing the number of case manager positions; and redesigning investigators' training, including components involving the Tennessee Bureau of Investigation.

Regardless of any effectiveness or efficiency gains realized in the future, assuming resources remain the same, the department's ability to meet its caseload goals is heavily dependent on the number of cases received. Both regional staff and upper management acknowledged that it is often difficult to maintain the current caseload protocol due to influxes in the number of cases received. While the department may be able to influence the number of abuse and neglect allegations it receives through prevention and public education efforts, the number of cases received is outside the department's control.

New Child Death Review Process Has Been Developed

During the audit, we reviewed the new child death review process, focusing on the proposed child death review process procedures. We were unable to conduct detailed tests of the process because it had been in place for less than one week when our fieldwork concluded. However, based on our review of the proposed procedures, the new child death review process appears reasonable and appropriate. As the process is implemented, the department will need to monitor the process and make changes as needed.

As a part of the ongoing Brian A. v. Bill Haslam lawsuit, the U.S. District Court instructed the Department of Children's Services (DCS) to revise the internal process for investigating child deaths related to abuse and neglect. In response, the department developed a new process, which officially went into effect on August 27, 2013. The first case under this process started on August 29, 2013, and was expected to be completed by early December 2013. Department staff will also use this process to retroactively review all cases going back to January 1, 2013.

New Reviews Conducted by Regional Teams

The new process will review child deaths or near deaths (conditions resulting from abuse that place a child in serious or critical condition as certified by a physician) of any child in state custody at the time of the event or when DCS is notified by an outside party, such as the police,

that a child's death may be due to abuse or neglect. Other cases can also be investigated at the Commissioner's discretion.

All cases will be reviewed by a team in the child's home region. The four regional teams cover:

a) Group 1: Shelby, Northwest, Southwest;

b) Group 2: Mid-Cumberland, Davidson, South Central;

c) Group 3: Upper Cumberland, Tennessee Valley, East; and

d) Group 4: Smoky Mountain, Knox, Northeast.

Each regional team includes a safety analyst, a nurse, a regional administrator, a Child Protective Services representative, a special investigations unit representative, an unrelated resource parent representative, and an independent physician.

Every review must be completed within three months of the child's death or near death. In the past, the lack of timely autopsy reports tended to slow down the review process. However, the new process allows for conclusions to be drawn even if the autopsy results are not available within the three-month time period. In this circumstance, the case will be revised when the autopsy results are received.

As part of the review results, the regional team will make prioritized recommendations to the department to avoid future deaths and near deaths. Level 1 recommendations require minimal department resources to complete. For example, a death review may uncover that there is a surviving sibling whose situation has not been adequately investigated or addressed. A level 1 recommendation could include contacting the caseworker to ensure that this investigation, which would be within existing resources and within the normal, existing course of business, occurs. Level 2 recommendations are those that can be implemented with reasonable effort and moderate resource allocation; they do not require DCS senior executive approval. For example, a level 2 recommendation could suggest that Child Programs staff create an internal webpage for caseworkers that defines various terms. In contrast, level 3 recommendations require senior executive approval to be implemented, due to the considerable effort and increased resource allocation required. For example, a recommendation to hire additional caseworkers to lower caseloads would be a level 3 recommendation. Additionally, the teams will prepare a quarterly death review report summarizing all recommendations and actions taken, and will distribute the report to the Commissioner and Deputy Commissioners within 30 days of the end of the quarter.

In addition, the department's Division of Child Health will prepare a semi-annual report for the Commissioner including the following information for each death or near-death case reviewed by the team:

- The cause and circumstances of the child's death or near death;
- the child's age and gender;

- any pertinent previous reports or abuse investigations (i.e., those directly related in time and substance to the abuse or neglect that led to the death or near death);
- the results of pertinent investigations, with conclusions available following the closure of the case;
- the state services provided and actions on behalf of the child that pertain to the child abuse or neglect that led to the death or near death; and
- the number of cases that did not meet criteria for review.

Department's New Process Consistent With Other States

To assist in our review, we contacted several states bordering Tennessee to compare their processes to the department's new process. Tennessee's revised process appears to differ from, but not be inconsistent or incompatible with, those in the border states contacted. For example, North Carolina operates two child death review teams, a community protection team in each community, and a Department of Social Services central office child death review team. The community protection team recommends changes to policies and procedures when necessary. The central office death review team analyzes the child death cases resulting from protective issues and alters the policies and procedures where applicable. Similarly, Arkansas has an internal Department of Family and Children's Services process, as well as an external process, for reviewing child fatalities. Arkansas reviews death cases concerning any child that had involvement with supportive services or foster care within the previous 12 months.

Statutes and Department Policies Are Inconsistent in Describing an Administrative Finding of Child Abuse or Neglect

Statutes use multiple terms to refer to the department's administrative finding that a perpetrator has committed child abuse or neglect, including the following:

- Section 37-1-607(a)(1)(A)(iii), *Tennessee Code Annotated*, refers to a substantiated or unsubstantiated case within the context of child protective team investigations;
- Section 37-1-406(i) and (k), *Tennessee Code Annotated*, refers to an indicated or unfounded determination within the context of the department's investigation responsibilities of mandatory child abuse reports;
- Section 37-8-802(6), *Tennessee Code Annotated*, refers to an indicated incident within the context of the Second Look Commission; and
- Multiple subsections of Section 71-3-507(a)(1), *Tennessee Code Annotated*, refer to the perpetrator as "indicated" to refer to administrative findings of abuse in both the department and the Department of Human Services.

Although staff stated that the department is accustomed to dealing with these inconsistencies, they have the potential to confuse the public and stakeholders. For example, because statutes use a variety of terms, any one of the department's policies addressing such

administrative findings can be viewed as using terms inconsistent with at least one of the relevant statutes. In its 2011 annual report, the Second Look Commission reported that terminology in the department's policies and procedures is inconsistent with the terminology used in statutes pertaining to the department. Specifically, the word "indicated" is used by the department in its policies to classify the results of an investigation, whereas the word "substantiated" is used in Section 37-1-607, *Tennessee Code Annotated,* to describe the same classification. In addition, the Second Look Commission found that the difference in terminology can result in confusion, specifically among individuals participating in Child Protective Investigative Team meetings.

The Commissioner of Children's Services stated to auditors that he prefers the term "substantiation" and will consider introducing legislation to make the statutory language more consistent. The General Assembly may wish to consider addressing variations in the terms used to describe the department's process of administratively finding that a perpetrator has committed child abuse or neglect, by changing the statutory language to be more consistent. If the General Assembly changes statute, the department should review its policies and make them consistent with statute.

RESULTS OF OTHER AUDIT WORK

Child Abuse Hotline Screening Processes Are Changing

Auditors were unable to assess how Child Abuse Hotline personnel assign child abuse and neglect referrals for either investigation or assessment, as well as how they assign a priority level to the referral, because the process is undergoing major changes. Under Administrative Policies and Procedures: 14.3, hotline staff are required to screen all reports of child abuse and neglect and make several determinations. Among the most important decisions is whether the allegation meets the statutory and department definitions of child abuse or neglect. If so, hotline personnel determine if the referral should be assigned to the region for investigation or assessment. In addition, hotline personnel assign a priority level to the referral. The priority level determines how quickly regional case managers must respond to the referral, with the highest priority requiring case manager response with 24 hours.

Screening Procedures Changing

During the course of this audit, the hotline was undergoing massive changes, and hotline management anticipates future additional changes to the tools and processes case managers use to screen reports. The changes, which are so significant that we could not properly assess the process as part of the current audit, include

- replacing the call center telephone management software;
- reducing the time required to make a screening decision by allowing experienced, proven hotline caseworkers to make screening decisions. While case managers

previously made these decisions, the decisions were not final and could not be implemented until reviewed by a supervisor. Screening decisions by selected, experienced hotline workers now go immediately into effect, with daily supervisory review occurring retroactively.

- improving the department's centralized computer system's intake screens, which are used to guide and make screening decisions; and
- revising the manual that guides caseworkers in making the key screening decisions.

Once these changes are implemented and enough time has passed to obtain data, department management will be in a better position to assess the process used to screen hotline calls and make decisions.

ADMINISTRATIVE FUNCTIONS

BACKGROUND

The Department of Children's Services (DCS) has several administrative offices and divisions that assist the department with daily operations. These offices all report to the Commissioner.

Objectives

The objectives covered in this chapter were to:

1. determine to what extent the department's Office of Information Systems has adequately addressed the user or management problems associated with the Tennessee Family and Child Tracking System (TFACTS);
2. assess whether the department has adequately monitored that background checks are being completed for the persons who have significant contact with children;
3. determine whether state-funded adoption assistance and subsidized permanent guardianship payments were correctly made for eligible children;
4. determine how complaints from parents about missing, duplicate, or over payments are tracked, and to determine what steps are taken by the department's fiscal staff to remedy these identified payment errors in a timely manner; and
5. determine what steps the Office of Information Systems has taken to obtain a technical review of TFACTS, as recommended by the March 2012 Comptroller's report on the implementation of TFACTS.

Organization and Functions

The department's administrative offices and divisions are described below:

Information Systems - The Office of Information Systems (OIS) oversees the implementation of information technology in the department and provides technical support to various personnel. Functional areas within OIS include application management, data management, and IT customer service and support. Along with providing technical support for the department, OIS is responsible for overseeing TFACTS, which was implemented in August 2010 and serves as the state's official Statewide Automated Child Welfare Information System. TFACTS is a partially federally funded information system, and to meet federal requirements the system must act as the state's official record for child and family cases.

Finance and Budget - The Office of Finance and Budget provides fiscal services for the department, including general accounting, accounts payable, financial planning, budgeting, revenue maximization, trust accounting, and eligibility services for foster care, adoption assistance, and subsidized permanent guardianship payments. This office also provides support for the region's fiscal services and the youth development centers. The Assistant Commissioner over finance and budget oversees this office.

Risk Management - The Division of Risk Management is composed of five units that manage risk within the department: program accountability review, licensure, provider quality, internal audit, and internal affairs.

Administrative Procedures - The Division of Administrative Procedures is responsible for all hearings and appeals about departmental rulings. These hearings are governed by the Uniform Administrative Procedures Act.

General Counsel - The Office of the General Counsel provides legal advice and counsel to the Commissioner and the department's employees.

Communications - The Office of Communications provides information about the department to the public, researchers, and the press.

Human Resources Development - The Human Resources Development Office oversees personnel functions, including the hiring and selection process, administration of benefits, and the performance management system. The office is also responsible for employee training and professional development, as well as resource parent training.

Facilities Management - The Facilities Management Office is responsible for overseeing the maintenance of all of the department's state-owned properties, three youth development centers, and all leased properties.

Quality Control - The Division of Quality Control assesses child welfare practices, outcomes, and compliance by using data and results to guide policies and practices. This data is collected through quality service reviews, continuous quality improvement, and program evaluation. The

division also monitors compliance with Council on Accreditation standards, American Correctional Association standards, and the Prison Rape Elimination Act.

Along with the offices and divisions listed above, the department's administrative functions include Customer Focused Government (a Governor initiative with the objective of providing the best service at the lowest possible cost) and Special Projects.

FINDINGS

5. Although the department has made efforts to improve the Tennessee Family and Child Tracking System, additional changes are needed to ensure the system is fully functional

Finding

Since implementing a new child welfare information system, the Tennessee Family and Child Tracking System (TFACTS), in August 2010, the Department of Children's Services has faced numerous documented system problems. While the department has worked to improve the system, users continue to report problems. Additionally, the department needs to continue to address auditors' and other external experts' concerns.

Users and Contractors Continue to Report Difficulties Using TFACTS

Users and external professionals who recently reviewed TFACTS continue to report problems with the system. During interviews that auditors conducted with department staff across the state between June 2012 and September 2013, TFACTS users continued to report numerous issues negatively impacting both management efficiency and the day-to-day field operations. Some of these problems include uncertainty about the reliability of system-generated reports, the system's inability to generate key reports, challenges locating information in the system, difficulty using the search function, and the system's slow speed. Additionally, a department-hired private contractor, Gartner Inc. (Gartner), published a report in April 2013 that included a variety of recommendations to improve TFACTS. Likewise, the Brian A. Technical Assistance Committee issued a TFACTS evaluation in April 2013, which included several recommendations to enhance TFACTS' ability to provide required data to the federal courts as part of the Brian A. v. Bill Haslam Modified Settlement Agreement and Exit Plan. [8]

Users and Contractors Report Data Reliability Challenges

Users and external stakeholders report numerous problems with TFACTS. First, while some users believe that the data in the reports they use are reliable, many others report finding inaccuracies in some system-generated reports. As a result of this inaccurate data, some

[8] Brian A. v. Bill Haslam is a class-action lawsuit that was filed against the state in 2001 on behalf of children in DCS custody. In 2011, a modified settlement agreement and exit plan was created for Brian A. v. Bill Haslam and included several requirements for the state to uphold in order to ensure that children in DCS custody receive proper care. The Brian A. Technical Assistance Committee consists of child welfare experts who assist the state in implementing these requirements.

personnel resort to verifying the reliability of certain reports generated in TFACTS. For example, some personnel compare system-generated reports against individual case information in TFACTS, as well as against case paper files. Numerous other users have created manual logs outside of TFACTS to keep track of case information.

A 2011 internal assessment conducted by the department reported that TFACTS was built and implemented without important features to ensure data reliability in the system. For example, the department revealed that some essential fields do not have built-in, automated data validation controls. Similarly, insufficient staff training has resulted in users continuing to enter information incorrectly in certain places in the system.

The department reported that in 2012, it implemented 32 validation controls to ensure users are entering information into the correct data entry fields. However, the department acknowledges that additional data controls are needed in the system and will be implemented in the future.

Required Reports Not Generated

Although some staff question data validity in TFACTS printouts, others report that some required reports are not being generated from TFACTS. As a result, in some department divisions, personnel create manual tracking documents outside of TFACTS. For example, a report detailing the number of cases every caseworker is carrying is not currently generated from TFACTS. Department upper management acknowledges that such a functional caseload report should be the primary management tool to allocate caseworker resources within the regions.

According to management, the department previously generated the caseload report from TFACTS but suspended production because of obvious problems with the report itself. While the department is working to address these problems, every regional Child Safety office is using a manual spreadsheet to track cases assigned to each caseworker and to balance caseloads among staff.

Another report not currently generated by TFACTS would be useful to the department's Division of Juvenile Justice. Currently, there are no reports that contain information about children who are classified as non-custodial or Interstate Compact on Juveniles cases; as a result, personnel maintain manual tracking logs and later manually reconcile them to information in TFACTS.

Difficult to Use Search Function

During our fieldwork, department personnel also reported problems with the TFACTS search function. When case managers search for a case in TFACTS, if they do not spell a name exactly as it was entered into the system during the initial intake process, the search engine will not yield any results for the case. Additionally, unintended search results can appear if the spelling is changed by just one letter. Members of the public often do not know the correct spellings when reporting potential child abuse and/or neglect to the department's Child Abuse Hotline. Also, department staff may mistype a name when initially entering data into TFACTS.

In contrast, the prior system reportedly had the ability to look for names that were not spelled exactly the same, which can be critical when dealing with thousands of children and the general public.

When hotline workers enter a misspelled or unclear name into the system's search engine to determine if the department is either currently investigating a reported child's situation or has done so in the past, the search engine will return no results, suggesting the department has no history with the child, even if history exists. If Child Abuse Hotline workers must struggle to search for a child's case history and locate critical information regarding the case in the system, the process for reporting child abuse and neglect may be delayed. Additionally, a worker may unnecessarily open a new case in TFACTS and not be aware of previously obtained information in investigations and other department operations.

Although the department and Compuware (the current vendor servicing TFACTS) made several improvements to the search function in August 2012, the department's May 2013 field surveys found that users are continuing to experience difficulty searching for information in TFACTS, especially in the Child Abuse Hotline call center. The department is proposing several new changes to the search engine to improve accuracy in locating case information.

Cumbersome Functionality

Frontline department personnel, including case managers and program personnel, also reported that because TFACTS is so cumbersome, it can be difficult to locate vital case information in the system. During our fieldwork, auditors conducting file reviews as a part of this audit (see page 9) experienced problems when searching for information in TFACTS. For example, we sometimes struggled to find important child abuse and neglect investigation case information because of the multiple "mouse clicks" required for users to locate information in the system.

The department's Information Systems staff acknowledged that TFACTS' "cumbersomeness" is a "significant" issue. Therefore, beginning in late 2013, the department is planning a series of projects to improve the system's usability, as well as to introduce a new user interface.

Slow Speed and Unexpected Log-outs

Department personnel also report other problems with TFACTS. First, many users report that TFACTS' primary technical problem is that its slow speed hinders their ability to complete their job responsibilities in a timely manner. Second, users report that TFACTS sporadically logs users out of the system without warning, resulting in a significant loss of work and personal frustration.

The department has begun using dynaTrace, a tool used to locate and correct areas within the system that are experiencing slow speeds. This tool produces a list of slow-running transactions within the system and identifies any sources contributing to the system's slowness.

Department Has Increased Avenues to Identify and Address User Concerns

In addition to addressing specific user concerns, the department is working to improve its overall sensitivity to users' TFACTS problems. The department implemented several avenues for TFACTS users to report issues and receive assistance from the department's Office of Information Systems. The office designated field customer care representatives in each region. Employees and private providers report TFACTS issues to the representatives, who provide hands-on, onsite technical assistance; attend meetings with central office staff to report user TFACTS issues; and communicate back to users on actions the office takes to address their concerns.

Follow-up on March 2012 Comptroller's Report on the Implementation of TFACTS

As with user-reported problems, the department has taken some steps to address the recommendations identified in the March 2012 Comptroller's report on the implementation of TFACTS. However, the department needs to take additional steps to satisfactorily address the problems.

Financial Reporting

First, the Comptroller's report found that the department's fiscal office used manual processes to maintain financial reporting because of TFACTS' problems. However, despite efforts to fix the problem, the department's own hired expert found that it needs to do more. The department hired Gartner in part to examine and advise on its progress to improve TFACTS' financial reporting capabilities. In April 2013, Gartner reported that the department had begun conducting monthly fiscal business workflow sessions to examine how the financial functions in TFACTS could better meet the needs of the fiscal office. However, Gartner also found that the department needs to continue to improve TFACTS' financial functionality to reduce the number of manual processes that personnel are currently using to maintain financial reporting and "to comply with SACWIS requirements." TFACTS is Tennessee's Statewide Automated Child Welfare Information System (SACWIS), a federally funded information system developed to support family preservation, foster care, and adoption management in Title IV-B/IV-E state agencies. States must agree the SACWIS is the state's sole case management automation tool and official case record for all children and families served by the Title IV-B/IV-E state agency.

OptimalJ Software

The Comptroller's report also found that TFACTS was dependent on an unsupported development software, OptimalJ, which has since been discontinued by its vendor. However, according to the Brian A. Technical Assistance Committee report, only certain functions of TFACTS now require the use of OptimalJ since the software was not used to develop the majority of the codes. The committee's report further states "if the department discontinued using OptimalJ, TFACTS would continue to function exactly as it does today."

Although TFACTS can function without OptimalJ, the department is still taking steps to ensure it has adequate resources to maintain the TFACTS functions that are supported by

OptimalJ. According to both Gartner and the Technical Assistance Committee, the department is working with OptimalJ's vendor to ensure that it is able to maintain the program codes that were generated using OptimalJ. The department is also determining what steps should be taken if it decides to retire these codes in the future.

Insufficient Training

The Comptroller's report found that personnel received insufficient training during the TFACTS implementation. Consistent with this conclusion, the Technical Assistance Committee report surveyed a variety of users on their experience with the initial TFACTS training and found that many caseworkers felt the training was not as effective as it could have been because it was not "hands-on." According to the Technical Assistance Committee, the department has fully acknowledged its insufficient training in the past and is taking steps to improve future TFACTS training. For example, training will no longer be outsourced; it will be provided directly by the department using permanent in-house TFACTS trainers. During our review, we also observed that the department had implemented a "TFACTS Playground" application, which allows personnel to navigate within a simulated version of TFACTS, learning how to better use the system without risking changes to critical data.

System Data Defects

The Comptroller's report also noted that department management reported numerous data defects in TFACTS, which were outside the scope of the Comptroller's review. However, several subsequent TFACTS reviews completed by groups charged with addressing those defects, found that a majority of the defects originally reported by the department were incorrectly prioritized based on their significance and were not actual data defects. Although the scope of this audit did not analyze the extent of the system's data defects and the efforts to remedy them, both the Technical Assistance Committee's review and the Gartner review of TFACTS concluded that the department has adequately reexamined all data defects, has identified the major defects within the system, and is taking appropriate steps to address all of the data defects.

Recommendation

We recommend seven areas of improvement for TFACTS' continued technical success.

First, the Department of Children's Services needs to improve TFACTS' reporting quality and accuracy of data by identifying which important data fields lack sufficient validation features and then adding those features. User training on data entry fields should be improved to ensure users enter data into the correct field. The department should also continue efforts to make operational reports, such as reports on caseworker caseloads and on non-custodial juvenile justice cases.

Second, the department should continue to improve users' abilities to search for existing records in TFACTS. Changes should be suitable for users' needs and correctly executed and the

department should determine whether the in-house development team or Compuware would be the best choice for implementing the changes.

Third, the department should proceed with its plans to reduce the cumbersomeness of TFACTS. The department should complete projects to enable users to more easily navigate throughout the system and to interact with TFACTS using a more efficient user interface.

Fourth, the department should continue to identify and correct areas within TFACTS that are experiencing issues with slow speeds or unexpected log-outs.

Fifth, as Gartner recommended, the department should continue to improve the financial functionality of TFACTS to reduce the number of manual processes that personnel currently use to maintain financial reporting and to comply with SACWIS requirements.

Sixth, the department should continue to comply with both Gartner's and the Technical Assistance Committee's recommendations to ensure that codes originally written using OptimalJ are adequately maintained by trained personnel. If the department decides to stop using the OptimalJ codes, it should implement a plan to successfully transition the system.

Seventh, the department should continue to improve and expand its in-house TFACTS training sessions for employees/users, including providing hands-on, department-wide training to ensure that all users are capable and confident with TFACTS.

Management's Comment

First, we concur. The department recently established a Reports Center of Excellence (RCoE). Amongst its purposes, the RCoE is charged with working with its business customers to evaluate each report for data quality, and then provide feedback to the business owner as to steps available to increase the quality of the data available for reporting purposes. As a part of this effort, an examination of guard rails needed but missing will be a key source of changes to be made to the application. In turn, the Program Review Committee (PRC) for each line of business and the Management Advisory Council (MAC) will prioritize the work to be completed.

A key component in enhancing overall reporting capabilities for TFACTS was implementation of the new TFACTS data warehouse in December 2013. With this implementation, the department has an integrated data warehouse that includes real-time tracking and decision support. In 2014, by marrying data warehouse enhancements, improving program process discipline and ongoing improvements to TFACTS training, OIT expects the timeliness and accuracy of reports to be greatly improved and all reporting and tracking to come from TFACTS data. The improvements in 2014 will also be supported by the recent work approved as a priority by the MAC, which aims to clarify and enhance the functionality in TFACTS with respect to case assignment roles. This work, when completed, will make it easier to monitor and report on caseloads across all program areas, including case types and workload metrics.

Second, we concur. As noted in the audit report, in conjunction with technology partner Compuware, the department made extensive changes to the search feature in TFACTS during 2012. The intent was to address the then identified issues with the search feature as it was extant following system deployment in 2010. While the changes made in 2012 provided some relief to users of TFACTS, continuing dialogue with the user population in 2013 has made clear the need for still further changes to the search function. The department anticipates partnering with users in 2014 to develop a set of user-driven search requirements that will be implemented by Compuware, internal staff, or a combination of the two. This ongoing dialogue will also examine whether as a matter of strategic positioning, the existing search engine currently in use by TFACTS continues to be the most prudent choice for providing this capability.

Third, we concur. As part of the feedback received during 2013 visits with TFACTS users across the state, it was clear that the TFACTS UI/UX was the most sought after set of changes to the application. This was a confirmed observations made in a number of earlier assessments, including those by the Brian A. TAC and Gartner Consulting. The department intends in 2014 to embark upon a major upgrade to the TFACTS UI/UX, building upon foundational work executed by Compuware in 2013.

Fourth, we concur. The department recently completed its migration to the new South Data Center (SDC). With the newer architecture/hardware/software available at the SDC, we are optimistic that overall performance of the application will improve, including specifically infrastructure-related components that have often in the past given rise to network, bandwidth and application stability caused issues. With respect to the Child Abuse Hotline function, in 2013 the department completed what in essence was a complete hardware refresh for staff whose primary job is to take child abuse referrals. Already in evidence as benefits of this refresh are reduced numbers of abandoned calls and greater levels of staff productivity. In 2014, the department plans to increase its use of proactive monitoring to achieve self-initiated remediation/mitigation of performance issues rather than the generally reactive incident management approach of the past.

Fifth, we concur. The department continues to devote an entire internal development team, as well as appreciable contractor resources, to the enhancement of the fiscal component within TFACTS. In general over the last two years, approximately 1/3 of the changes to TFACTS, whether defect remediation or enhancements, have been to the fiscal component.

Sixth, we concur. The department placed a significant emphasis in 2013 on training internal staff to be able to competently and confidently make changes to the OptimalJ models when needed. This successful endeavor included the remediation of the OptimalJ models which were delivered when the TFACTS system was placed into production in 2010. The department intends to fully minimize any further technical debt aggregated due to the use of the OptimalJ IDE, and to continue a steady, systematic movement away from long-term dependence upon this obsolete technology.

Seventh, we concur. The department's OIT took the opportunity in the latter half of 2013 to implement a new approach to TFACTS training, one in which we partner far more closely with business owners to develop training curricula and facilitate/conduct training with staff. A part of

this approach has been to marry policy and procedure components with the TFACTS "Point and Click" training. This new approach has been central in successfully training nursing staff at the YDCs, resource parent support staff, and in the training for the recent Extension of Foster Care Services to youths over 18 years of age. In 2014, current plans call for utilization of this new approach to play a central role in training for serious incident reporting, case assignment roles, and permanency planning training in 2014.

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6. Some of the department's background check files lack sufficient documentation that required checks and supervisory reviews had been completed, raising questions about the appropriateness of approval of volunteers and resource homes providing services to children

Finding

Sections 37-5-511(a)(1) and (2), *Tennessee Code Annotated,* requires that "each person . . . applying to work with children as a paid employee with a childcare agency . . . or with the department [of Children's Services] in any position in which significant contact with children is likely in the course of the person's employment" should submit to a series of background checks. The Department of Children's Services' (DCS') policy further specifies the types of checks required for employment, including a criminal history check, a TBI/FBI fingerprint check, a national sexual offender registry check, a DCS records check (to ensure the person has not been indicated in a child abuse or neglect case), and a Department of Health abuse registry check. Through state law and departmental policy, these background checks apply to several groups of people who have access to children during the performance of their job duties, including DCS employees and volunteers; private-provider employees and volunteers; DCS resource home parents and adult residents; private-provider resource home parents and adult residents; and direct-care vendors (i.e., those persons who directly provide services to children under the custody or supervision of the department).

Auditors first reviewed the internal controls in place to determine whether the department's monitoring of these groups appeared adequate to reduce the risk of safety to children. If we did not determine that monitoring was adequate, we analyzed a sample of background check files to identify areas of weakness. We reviewed files for DCS volunteers; DCS resource home parents and adult residents; and private-provider resource home parents and adult residents, and found missing or inadequate documentation of completion of required background checks, approval of resource homes prior to all background checks being completed, and inadequate documentation of supervisory review. Because of these weaknesses, it was unclear whether some volunteers and resource homes should have been approved to work with children in DCS' care.

Assessment of Monitoring Processes

We determined the department had adequate monitoring practices for DCS employees and for private-provider employees and volunteers. For DCS employees, the department's Human Resources Development Office performs personnel file audits annually to ensure that the documentation in the files is in compliance with departmental policy and procedures. Reviews of background check documentation for all new employees and 25% of existing employees are included in these audits. The department considers any missing documentation related to background checks to be a policy violation and requires immediate remediation. The department's program accountability review (PAR) staff monitor private providers that contract with the department to serve children in custody. As part of their annual monitoring visits for these providers, PAR staff review the personnel files for at least 10% of direct-care or treatment personnel. According to department personnel, files for private-provider volunteers with direct access to children are reviewed in the same manner.

We did, however, identify potential weaknesses in the monitoring of background checks for several groups of people with access to children—DCS volunteers; DCS resource home parents and adult residents; and private-provider resource home parents and adult residents. While department volunteers with access to children require certain background checks, a review of the volunteer files is not included in the current Human Resources personnel file audits. Furthermore, our review indicated that there are not specific personnel in the regions who have clear responsibility to monitor volunteers' background check documentation. Department personnel did state that procedures are being changed to include volunteer files in the department's personnel file audits. The approval and monitoring of DCS resource homes, including the maintenance of background check documentation for adults living in the home, occurs at the regional level. According to department personnel, central office personnel are responsible for additional monitoring. Private providers approve their own resource homes; the department does not directly monitor these homes. The department's monitoring of direct-care vendors is a new process. While the process was evolving during the course of this audit, we reviewed the background check monitoring aspects of the process and reported our observations about its weaknesses on page 55.

Background Check Files Reviewed

We analyzed a sample of background check files for the three groups identified above as having potential weaknesses in the background check monitoring process. These samples were chosen randomly from five randomly selected DCS regions throughout the state. Detailed information for each group we reviewed is described below.

- *DCS Volunteers*—Many volunteers participate directly in the operation of departmental facilities and programs and may have direct contact with children during the course of their service. Our review included 100% of a region's active volunteer files for volunteers involved with the department on or after July 1, 2012. From the five regions included in our sample, we reviewed a total of 33 files.
- *DCS Resource Home Parents and Adult Residents*—Resource home parents provide care and housing for children in DCS custody/supervision. The children may or may

not be related to the resource home parents, but, despite any prior relationship, resource homes must go through an approval process that includes background checks on resource home parents and other adults living in the home. In each of the randomly selected regions, we obtained a count of resource homes from the department and reviewed 10% of the homes, for a total of 115 resource home files.

- *Private-Provider Resource Home Parents and Adult Residents*—Private-provider resource homes are essentially the same as DCS resource homes, except that the private provider conducts approval and monitoring of these homes. DCS places children in these homes and maintains overall responsibility by monitoring the private-provider organizations for compliance with policy. Our sample of private providers was the same as those private providers chosen for our review of juvenile justice evidence-based practices (see page 69). We reviewed a judgmental sample of 52 private-provider resource home files.

Background Check Completion and Supervisory Review Weaknesses Identified

Before volunteers or resource homes are approved to work with children, the department must ensure that all background checks have been completed and appropriately reviewed. Without documentation that background checks are complete, it is unclear whether volunteers or adults in resource homes have had criminal or other violations that could put the safety of children in the department's care at risk, and if these volunteers or homes should have received approval to start or continue working with children. Review by a supervisor should act as a final check to ensure that all required steps in the approval process have been completed and that the documentation gathered supports the approval of the volunteer or home to work with a child in DCS custody/supervision.

Our review of background check files found numerous instances when required forms and other documentation were not included or not fully completed. Major weaknesses found during our file reviews of DCS volunteers and DCS and private-provider resource homes are detailed below.

DCS Volunteers

Of the 33 files reviewed, 31 (94%) had at least one weakness identified. For 20 volunteer files (61%), we found missing or inadequate documentation of required background checks during the initial review (prior to the start of the volunteer's service) or during an annual review. The missing or inadequate documentation covered a number of background check types, including the local law enforcement check, TBI/FBI fingerprint check, national sex offender registry check, DCS records check, Department of Health abuse registry check, and meth offender registry check.

In two files reviewed, we noted that annual updates to the background checks had not been performed. In these cases, the volunteers were approved in July 2011 but did not start until September 2012. The initial background checks were performed close to the application approval date and had not been updated since (nearly two years at the time of our review).

In eight files, the departmental form used to document supervisory review of the background checks was missing, and 6 of the remaining 25 files did not have a signature indicating that supervisory review had occurred.

DCS Resource Home Parents and Adult Residents

DCS policy requires that resource home files contain certain forms to document that background checks were actually performed. Of the 115 files reviewed, 41 files (36%) had at least one weakness identified with their background checks. Three files were missing the form that documents when the background checks were performed, completed at both the initial check prior to approval and at each renewal. The initial forms were missing for a total of 13 individuals (multiple individuals may live in a single home). Two files were missing the most recent renewal form. The missing forms prevented auditors from fully reviewing the homes and individuals.

Six homes (eight individuals) were approved prior to all required background checks being performed. Also, 9 homes (19 individuals) were approved without all required background checks being performed or properly documented. The background checks not performed (or not performed prior to approval) or not properly documented included checks of/with the local law enforcement, TBI/FBI fingerprint, national sex offender registry, DCS records, and Department of Health abuse registry.

Three homes (seven individuals) were approved without required documentation on the background check summary form of a review by an appropriate DCS employee. Two homes (four individuals) were reapproved without the same documentation of a review.

Private-Provider Resource Home Parents and Adult Residents

Of the 52 homes in our sample, we identified at least one weakness in 25 files (48%). Six homes (nine individuals) were approved prior to the completion of all required background checks. Ten homes (16 individuals) were approved without all required background checks being performed or properly documented. The background checks not performed or not properly documented included checks of local law enforcement, the national sex offender registry, DCS records, and the Department of Health abuse registry. Fourteen homes were missing the required form that documents when the background checks were performed, which is completed at both the initial check prior to approval and at each renewal.

One home was approved without documentation on the background check summary form of a review by an appropriate employee. Another home was reapproved without the same documentation of a review.

Recommendation

The department should ensure that all required background check forms are completed, signed, and reviewed prior to approval. The department should review the existing policy, revise

it as necessary, and provide additional training to ensure all employees are aware of and understand the policy and its requirements.

The department should also perform periodic reviews of a sample of background check files to help ensure background checks are appropriately completed and documented.

Management's Comment

We concur. Over the last several years the department has improved its practice regarding the vetting of agency volunteers and resource parents (DCS and private provider) in several different areas. As our agency continues with re-accreditation by the Council On Accreditation (COA) and with movement toward exit from the Brian A. Settlement Agreement, we are required to have processes and controls in place to ensure that anyone who has direct contact with children served by the agency have appropriate background checks completed, prior to their contact with clients. These processes and controls include:

- Quarterly Case Process Reviews (CPRs) of a sample for each population that requires a background check before working with children.
- File Assessment/Review by the Departmental Resource Home Evaluation Team (D-RHET) of approval documents for each resource home, including background checks, prior to IV-E reimbursement of the home
- File Assessment/Review by the Departmental Resource Home Evaluation Team (D-RHET) during the biennial reassessment of the resource parent
- Other targeted reviews of case files. Most recently, a targeted review by the Brian A. Technical Assistance Committee office revealed a 97% completion rate and documentation of background checks for expedited resource parents prior to placement of children into the homes.
- In July of 2012, our agency successfully passed its Federal Title IV-E Foster Care audit that reviews resource home and congregate care approval documents, which also indicates that background checks and other necessary requirements to provide foster care are being completed timely.

In addition to the above, the Division of Human Resources has instituted the following steps to verify that DCS volunteers have had the appropriate background checks completed.

- By October 2013, DCS had completed revisions to volunteer procedures. Background checks of volunteers was clarified as a specific responsibility of the regional Volunteer Coordinator. [Volunteer Coordinator's Procedures Manual, "Background Investigations," p. 9].
- In addition, the list of contents that are required to be in the volunteer file specifically includes background check results. [Volunteer Coordinator's Procedures Manual, "Volunteer Files", p. 13].

- Volunteer Coordinators have received and provided input to the most recent revisions of the Volunteer Coordinator's Procedures Manual. These communications outlined the ongoing responsibilities and requirements for documentation of background checks. [Meeting Minutes, Volunteer Coordinators' Conference Call, 11/20/2013]

- In 2014, the personnel file audit procedure will include a review of volunteer files. Thus, in 2014 the agency will actively check and audit volunteer files to assure that background checks for volunteers occur prior to their volunteer activity and that required annual background checks occur in accordance with DCS policy requirements.

The agency has an ongoing commitment to ensure compliance with the completion of required background checks for volunteers and resource parents. We feel that the processes and controls that are currently in place will identify future concerns and any additional needs for further assessment or compliance with State statutes.

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7. The department should reassess its policies and the documentation maintained in Adoption Assistance and Subsidized Permanent Guardianship files to ensure that the necessary information is required and is included in the files

Finding

Adoption Assistance and Subsidized Permanent Guardianship payments provide financial support to families adopting children with special needs or assuming legal guardianship of children, respectively. Payments can include one-time expense reimbursements, medical benefits, or monthly payments. Both payment types can either be fully funded by the state, or partially reimbursed by the federal government through Title IV-E funding. A standard board daily payment rate is applicable to most children, with a higher rate paid to those eligible for special or extraordinary rates. Ensuring that payments are justified and distributed correctly is essential to proper departmental spending.

The Department of Children's Services' (DCS') policies require that each child's file contain certain forms and approvals to document the child's eligibility for Adoption Assistance or Subsidized Permanent Guardianship payments. This audit included a review of a sample of 56 state-funded adoption assistance files[9] and 61 subsidized permanent guardianship files.[10] Our

[9] After randomly selecting 5 of the department's 12 regions for testing, we identified children in those regions receiving state-funded AA payments during the period of July 1, 2012, through December 31, 2012. We randomly selected a non-statistical sample of 60 files for testing. However, only 56 adoption assistance files were tested (two received Title IV-E federal funding, the file for one had accidentally been shredded, and one received SPG payments).

[10] We identified children in the five tested regions who received SPG payments during the period of July 1, 2012 through December 31, 2012, and randomly selected a non-statistical sample of 60 for testing. However, 61 SPG files were tested because one child pulled for the AA file review was found to be receiving SPG funds, so we added that file to the review.

initial review of files for a sample of recipients receiving payments during the period July 1, 2012, through December 31, 2012, found missing or incomplete required documentation that limited our ability to fully analyze the files and raised questions about the recipients' eligibility for the payments and the appropriateness of the payment amounts. Additional documentation and explanation provided by the department after our fieldwork was completed addressed some of the auditors' questions regarding recipients' eligibility, but questions remain regarding the documentation maintained in the files, and staff's compliance with the department's policies. The department has very specific, detailed requirements for documentation that needs to be included in the files; however, our review found that those requirements are not always met. If the department were able to simplify those requirements, focusing only on documentation that was absolutely needed, it could potentially streamline the process, decrease documentation, yet still ensure that vital documentation is maintained in the child's file.

As noted above, we reassessed our initial analysis after the department provided additional documentation. Issues remaining after the review of additional documentation are detailed below.

Adoption Assistance (AA)

- 24 of the 56 files lacked the required form or similar document specifying the child welfare benefit counselor's decision on the eligibility of the child and the funding source of payments. However, for 18 of these files, the department later provided additional information documenting the child's eligibility. For 3 files additional information provided stated the child met special needs criteria but the supporting documentation was lacking. For 3 files, the department provided no additional information. An additional 3 files reviewed had the required form but did not indicate that the children had been deemed eligible for AA payments (one was deemed ineligible; two had no decision indicated).
- One file lacked (a) the form that documents the application of the adoptive parents for AA payments and DCS staff's decision on approval or denial of payments and (b) the initial form that documents payment terms and amounts for the child, provides adoptive parents with the rules and policies, and marks an agreement between the parents and DCS. Without these forms, we could not verify that the adoptive parents applied for assistance, that the department approved the application and payments, or that payments were made in the correct amount to the correct recipient.
- For 11 files, there were appropriate DCS personnel signatures on the application for AA, but no declaration on the form of the approval or denial of payments as required on the form and in DCS policy.
- Seven files had incomplete documentation verifying the application and approval decision for special or extraordinary payments for children when it appeared such documentation was required. An additional file had no required "rate decision" on the form. Without this documentation, we were unable to verify that special or extraordinary rates paid to the recipients had been authorized.

In addition, two files had daily payment rates different from the rate documented on the most recent agreement form in the file. The combined effect for the two files resulted in a net overpayment of at least $2,445. In one of these files, the department provided documentation than an overpayment had occurred and the department had made attempts to recover it.

Subsidized Permanent Guardianship (SPG)

- For 11 of the 61 files, the required form was missing but the department later provided another form that documents eligibility.
- For two files, the initial form that documents payment terms and amounts, provides guardians with the rules and policies, and marks an agreement between the guardians and DCS lacked an effective date. One file lacked the approval by a DCS employee on the form.
- For 13 files, there were appropriate DCS personnel signatures on the application for SPG, but no declaration on the form of the approval or denial of payments as required on the form and in DCS policy.

In addition, two files had daily payment rates different from the rate documented on the most recent agreement form in the file. The combined effect for the two files resulted in a net overpayment of at least $5,061.

Recommendation

The department should reassess the information that needs to be maintained in a recipient's file to document eligibility and approval for Adoption Assistance (AA) and Subsidized Permanent Guardianship (SPG) payments, the appropriate payment amount, and review by management. The department should then review its policies to ensure the policy focuses on the necessary information, and should require that staff include that information in the files.

The department should consider performing periodic reviews of a random sample of AA and SPG files to help ensure completeness of files, appropriateness of payments, and to identify areas where additional training is needed. Any overpayments identified should be recovered.

Management's Comments

We concur in part. Prior to March, 2008, eligibility information for a child may have been found in two different files – the child adoption assistance file and the child welfare benefits file. Subsequent to that date, child welfare benefit eligibility has been transferred to the child subsidy file via an eligibility certification form. The actual documentation remains in the child welfare benefit file. This has not been a problem in previous federal or state audits. The current audit finding does not specifically state that the certification form is not sufficient, but it appears that this is the conclusion. Moving forward, the department will develop a plan to

actually place applicable child welfare benefit file documents in the child subsidy file, so auditors won't have to look in two places for the necessary eligibility information.

The department already has a plan in place that ensures periodic review of a random sample of AA and SPG files. The Case Process Review (CPR) is a random quarterly review. Additionally, central office management conducts periodic reviews on special and extraordinary rate cases as well as reviews for subsidy cases for youth eighteen (18) and older.

Relative to the bullet points raised above our response is as follows.

Adoption Assistance

First Bullet: The department submitted follow-up documentation on January 13, 2014 to support the eligibility determination on 21 of the 24 cases that the audit found deficient in this category. On the 3 cases where documentation was not submitted, the department concurred with the finding. On the other 21 cases, we submitted the same set of documentation confirming eligibility. Based upon the feedback received from the audit office in their revised findings, we are unable to determine which 18 files had the documentation accepted and which 3 files had it rejected, or why it would have been rejected.

Second Bullet: The department concurred with the finding in this case.

Third Bullet: The department submitted appropriate signature pages and supporting documentation of eligibility for all 11 cases, but concurs that a box was not checked on the signature page of the Initial Application for Adoption Assistance in each of these files. Eligibility did exist in ALL 11 of these cases, because all appropriate eligibility documents were present. The deficiency was simply an oversight in checking a box above the signature line.

Fourth Bullet: On one (1) of the files we concur. On four (4) of the files the rates are no longer considered to be special or extraordinary rates (as explained during our meeting on January 10th), and the department's position is that these cases should not have been a part of any sample for special/extraordinary rates. The cases are considered as regular rates. On the other two (2) cases, we submitted the supporting documentation in the follow-up and don't understand why it failed to meet compliance standards.

The department does concur that two files had daily payment rates different from the rate documented on the most recent agreement form in the file.

Subsidized Permanent Guardianship (SPG)

First Bullet: Based upon this bullet, the department is concluding that the auditor's office accepted the subsequent documentation submitted for the 11 SPG cases.

Second Bullet: The department concurs with this finding.

Third Bullet: As was the case with the 11 Adoption Assistance files that had appropriate signatures and supporting eligibility documentation, the department concurs that a box was not checked above the signature. Again, eligibility existed in all 13 cases as supported by eligibility documents in the files. The deficiency was simply an oversight in checking the box above the signature.

The department does concur that two files had daily payment rates different from the rate documented on the most recent agreement form in the file.

OBSERVATIONS AND COMMENTS

The topics discussed below did not warrant a finding but are included in this report because of their effect on the operations of the department and on the citizens of Tennessee.

The Department Has Improved Its Processes to Detect and Resolve Payment Issues

The March 2012 Comptroller's report on the implementation of the Tennessee Family and Child Tracking System (TFACTS) noted deficiencies related to payments to families caring for children under the department's custody. First, the foster care phone-in system was disabled when TFACTS was implemented statewide. Second, the department did not have sufficient controls to prevent and detect when a payment to a family was missed, duplicated, or overpaid. Lastly, the department's oversight of the complaint hotline did not allow the department to determine the extent of missed or incorrect payments. Noting these deficiencies, the audit team interviewed department personnel regarding the payments to families to determine the steps the department has taken to improve controls over the prevention and detection of missing, duplicate, and overpayments. Also, we reviewed the processes the department has to identify, track, and address payment errors.

Payment Preventative and Detective Controls

During our review, auditors observed that, in an effort to decrease payment errors, the department has created new procedures to detect missing, duplicate, and overpayments. One such procedure is the use of "payment rosters" distributed to each of the department's 12 regions on a monthly or semi-monthly basis (depending on payment type). Each of the payment rosters lists the names of all children eligible to receive Adoption Assistance (AA), Subsidized Permanent Guardianship (SPG), or foster care payments. The department's 12 regional fiscal offices are responsible for reviewing each of their designated payment rosters to ensure that the payment information for each child is correct. After the AA and SPG payment rosters are approved by the regions, payments are distributed to each parent.

Similarly, before foster care payments are distributed, each region is responsible for reviewing their foster care payment roster to ensure each child's payment information is correct. Data from the approved payment rosters are uploaded into the department's foster care phone-in

verification system. Foster care parents are required to call into the phone-in system to verify their child's placement. An improved procedure requires that only after a foster care parent calls into the phone-in system will the parent receive payment.

The phone-in system and the payment rosters give the department an additional control to ensure payment information is correct before payments are distributed to parents. Similarly, the Independent Verification and Validation Technical Assessment on TFACTS, completed by Gartner in April 2013, determined that the department has taken adequate steps, such as the phone-in system, to implement controls to prevent payment errors. Department personnel have reported fewer payment errors since these new controls have been put in place.

Although the phone-in system has reduced payment errors, the system is prone to data entry errors because the system is cumbersome. In an effort to make the payment verification processes easier for resource parents, the department implemented an online verification system on February 5, 2013, in addition to the phone-in system. According to the department, the number of payment issues has decreased since implementing the online verification portal, and as of June 2013, 53% of resource parents were using the online portal.

Identification and Resolution Processes

Several processes have been implemented to identify, track, and address payment errors for foster care, AA, and SPG. As reported by department personnel, the majority of payment errors are the result of human or data entry errors. Some of the most common payment errors are the result of personnel either entering incorrect information into TFACTS or not entering data into TFACTS in a timely manner; parents not submitting documentation; parents entering wrong information into the phone-in system; or parents not calling into the phone-in system when required.

AA and SPG overpayments could also occur because parents fail to report a change in their child's placement, such as when the child no longer lives in the home, is no longer enrolled in school, or is placed in the department's custody. Unlike foster care placements, the department is not required by the federal government to verify with parents the placement of their child if parents are receiving AA or SPG payments. If a change in placement occurs, it is the parents' responsibility to notify the department.

Although the majority of foster care, AA, and SPG payment errors are reportedly the result of human or data entry error, payment errors may also result from technical issues in TFACTS and Edison. Department staff report, however, that payment errors caused by technical issues do not occur as often as they did when TFACTS was initially implemented.

Whether attributed to human error or technical issues, department personnel go through a series of steps to identify and resolve payment errors. The department is aware of a payment issue when a parent reports the error to their resource parent support worker, adoption subsidy specialist, regional fiscal office, or to the central office's customer care center. Department staff document and track payment errors on paper or electronically until the errors are resolved, although the process varies among the department's regions and the central office. When a

payment error cannot be resolved by regional personnel, usually because of a technical issue in TFACTS or Edison, the issue is escalated to the central office's fiscal division and future payments are delayed until the issue is resolved.

When a missed payment, overpayment, or underpayment is discovered and reported, the department must go through procedures to retrieve excess funds or pay additional funds to correct the payment. If a parent reports a missing payment, the regional fiscal office notifies the central office and submits a form to request that the parent receive the missing funds. In July 2012, the department created a new procedure to recover overpaid funds from parents. The regional fiscal office or program staff complete and submit a refund request form to the central office to notify the fiscal division that an overpayment has occurred and the amount of the overpayment. Central office staff send a letter to the parent detailing the amount of the overpayment and the repayment options. In the same manner, if a parent receives an underpayment, the regional fiscal office or program staff complete an underpayment request form documenting how much money the parent was underpaid and submit the form to the central office. Following approval, the central office staff send a check to the parent for the amount underpaid.

Department personnel reported that duplicate payments are now almost nonexistent due to the elimination of manual payments (payments that were manually entered into TFACTS as a result of the system's payment function not working correctly) within the regions. However, in the event that a duplicate payment does occur, the department requires that the regions complete the refund request procedure used to resolve overpayments.

While the Department Has Created a Process to Monitor Direct-care Vendors, Including Background Checks for the Vendors' Employees, the Process Has Important Gaps That Need to Be Addressed in Order for the Process to Be Effective

In the July 2010 Department of Children's Services Division of Juvenile Justice Performance Audit, auditors found that the division did not have policies and procedures for monitoring direct-care vendors (i.e., non-residential service providers), including obtaining and reviewing background check documentation for the vendors' employees. Subsequently, the department created a process for all direct-care vendors contracted through the department's delegated purchase authority to monitor these vendors' credentials, background checks, and quality of services. The process includes an application process, an initial approval to receive a contract, and a re-approval every two years to maintain a contract.

In December 2012, the department implemented the process by sending out applications to all direct-care vendors for these vendors to receive initial approval, which is required for all new contracts. The applications require the vendors to submit documentation on the employees' qualifications and licensure, employees' background check information satisfying the department's background check policy, and the service types offered. This documentation is reviewed by the department's provider quality unit and by an appropriate "service expert" within the department (e.g., nurse or psychiatrist) who can evaluate the employees' credentials. The provider quality unit has procedures for documenting, tracking, and addressing concerns

regarding the quality of the services provided by direct-care vendors. These reported concerns are considered as part of the initial approval and subsequent re-approvals.

Because of the newness of this process, we focused our review on the background check monitoring aspect of the process for 3 vendors (with 21 employees) that had been approved by mid-April 2013. Using the department's background check policy to review the documentation provided to the department, we found that 7 of 21 employees from 2 vendors (33%) were missing documentation that verified the background checks had been performed. The missing documentation items included the local law enforcement check (two of seven employees), Tennessee felony database check (four of seven), TBI/FBI fingerprint check (two of seven), national sex offender registry check (four of seven), meth offender registry check (five of seven), Department of Health abuse registry check (six of seven), and DCS records check (four of seven). Without this documentation, the department has little assurance that the vendor's employee does not have a criminal background that violates the department's policy and poses a risk to children.

The department's policy requires a form indicating that the background check documentation has been reviewed by an appropriate department employee. For 13 of 21 employees (62%), this document did not have a signature in the space assigned for the supervisory review. The remaining eight employees' files were missing this form. Since the development of this process is ongoing, the personnel within the department's provider quality unit may not have fully determined how to document the review of the background check documentation. Nevertheless, because auditors found extensive missing documentation, the department should consider performing a follow-up review of the completeness and veracity of these background checks.

We also found other missing documents required by the department's policy. However, it is possible that the department's disorganization of the vendors' files contributed to the missing or inadequate information. For example, department staff had some difficulty locating the vendors' files stored on the computer and e-mail server. When the files were identified, staff were unclear about which files contained what documentation from the vendors, and documents were not organized in a consistent manner (i.e., documentation for an employee may have been compiled in a single file, or separated into multiple files).

The department should confirm receipt of background check documents provided by the vendors to ensure the department's approval of the vendor is appropriate. This may involve having vendors resubmit documentation before the vendors are reauthorized to provide services to children. Furthermore, the department should establish a formal procedure for organizing, maintaining, and reviewing the documentation provided by the vendors.

The Department Is in the Process of Changing How Incidents Are Reported

Auditors reviewed the department's incident report process to determine the adequacy of the steps taken to respond to incidents involving children in custody. The department considers an incident as any event affecting a child or a program's operation, such as a medication error,

use of a restraint, abuse, or neglect. While we noted several concerns during our review, as discussed below, the department has since made significant changes to the process and the personnel who manage it.

Through our discussions with personnel involved in the incident report process, we found that the responsibilities for the process are widely distributed throughout the department. Various personnel are alerted to follow up on a specific incident, but those personnel felt they were not notified of other incidents that could involve the child, nor could they search within the incident report section of the Tennessee Family and Child Tracking System (TFACTS) for incidents beyond a specific report number. The department's Office of Information Systems was reportedly aware of this issue but had not remedied it at the time of our review. Therefore, personnel may not have noticed certain incidents requiring follow-up, and regional staff could not identify trends in incidents with specific children or providers that would need a more coordinated response.

One aspect of the incident report process was a qualitative review of all incident reports filed in TFACTS to identify follow-up issues. Personnel responsible for this review created a tracking spreadsheet to note issues regarding incomplete or unclear information within the report or timeliness of the report. When we reviewed several of these spreadsheets, we found a number of problems, including incomplete information regarding the assessment of the incident report's timeliness; possible duplicate report entries; gaps in the reports analyzed; and inconsistent and incomplete information regarding specific report concerns and locations of incidents. Also, only one person was mostly responsible for this qualitative review, and, as a result, there was a backlog to review reports and update the tracking spreadsheets. Because of these issues, we questioned the usefulness of these spreadsheets for management purposes.

As of July 2013, the department had made significant changes to the incident reporting process. According to the Assistant Commissioner for Quality Control, the collection and analysis of incident reporting data for the department will be centralized under Quality Control. The reviews of individual incidents, such as medication errors, seclusion, and restraint, will remain with the subject matter experts, such as the Medical Director or the Director of Nursing.

In April 2013, the department submitted a job order to make changes in TFACTS to improve the incident report function. The Project Review Committee reviewed the job order on July 25, 2013, and gave it a priority 1 rating, meaning that it is in the top layer of projects to be completed. Once the changes in TFACTS have been made, the reporting function will automatically notify the subject matter reviewer when an identified type of incident has been reported, and the system will track response and review time. The system will allow providers to pull their own data and will allow department staff to pull and report data on the provider scorecard. Two sets of incident report enhancements to TFACTS are scheduled to be released, one in December 2013 and one in January 2014.

In addition to following up on the timeliness and quality of reviews, Quality Control's goal will be to track and trend incidents by category and by provider to look for patterns and to identify corrective actions needed. As of late July 2013, according to the Assistant Commissioner, the department was already running targeted reports by incident type, such as

runaways, medication errors, etc., to assess information quality and timeliness. These reports are then sent to the field or subject matter expert for follow-up and correction.

RESULTS OF OTHER AUDIT WORK

The Department Conducted an Independent Technical Assessment of the Tennessee Family and Child Tracking System, as Recommended in the March 2012 Comptroller's Report

The March 2012 Comptroller's report on the implementation of the Tennessee Family and Child Tracking System (TFACTS) recommended that the department contract for an independent technical review of TFACTS. Following this recommendation, the department began bidding out the technical review in October 2012, and the Commissioner of the Department of Finance and Administration approved the contract for Gartner to conduct an Independent Verification and Validation Technical Assessment on TFACTS in November 2012.

Gartner began the technical assessment, which consisted of four phases occurring over a ten-week period, in late January 2013. The technical assessment's scope of work included:

- assessing whether previous assessments performed by the department and the Comptroller's Office identified all of the major deficiencies in TFACTS and its data warehouse;
- ensuring that the department is taking adequate steps to resolve the deficiencies identified in the previous assessments; and
- conducting a review of TFACTS' reporting capabilities and its data warehouse to determine if they are both aligned with the requirements of the Brian A. agreement and of other business processes.

Gartner completed its review of TFACTS and on April 18, 2013, released a report that contained several overarching recommendations and findings, as well as a status update of 123 items identified in the March 2012 Comptroller's report and the department's January 2012 internal TFACTS assessment. Several of the findings and recommendations from Gartner's review are discussed in Finding 5.

DIVISION OF JUVENILE JUSTICE

BACKGROUND

The Division of Juvenile Justice was created during the 2006 legislative session to coordinate services to the youth who have been adjudicated delinquent and to their families. The division also manages three youth development centers (YDCs) for male custodial youth with more serious delinquent offenses. As of October 31, 2013, approximately 16% (1,411) of children in the department's custody are adjudicated delinquent youth; the division supervises approximately 3,000 other children on probation or aftercare. The Deputy Commissioner for Juvenile Justice, who reports directly to the Commissioner, oversees the division.

Objectives

The objectives covered in this chapter were to

1. determine whether caseworkers are adequately supervising youth on probation or aftercare;
2. assess the availability of placement options appropriate for youth who have been adjudicated delinquent;
3. review the department's definition of recidivism, the procedure established for calculating the recidivism rate, and recidivism data;
4. determine how the department knows the treatment services provided to youth who have been adjudicated delinquent are effective;
5. determine how the department ensures that treatment services provided to youth in custody who have been adjudicated delinquent are evidence-based programs; and
6. assess whether the availability of services for youth who have been adjudicated delinquent and are on state probation or aftercare are sufficient.

Organization and Functions

Juvenile courts determine the adjudication of youth who have committed criminal offenses and can assign the youth to the custody of the department or to state probation supervision. If the youth is brought into custody, the department determines which placement setting would address the treatment needs of the youth. Similar to those dependent and neglected children the court assigns to the department's custody, youth who have been adjudicated delinquent and are in custody can be placed in settings ranging from a resource (foster) home to a level 4 hospital placement. Male youth between 13 and 19 years old who meet certain criteria could be placed in one of three YDCs where about 400 youth reside. In any placement setting, a wide variety of treatment and other services such as counseling, alcohol and drug treatment, or educational service are available for the youth. After the youth is released from custody, the

youth enters aftercare supervision. During aftercare, additional non-custodial (in-home) services are provided to offer continuity and supportive follow-up.

Youth placed on state probation are not in custody, but receive services in their home or community. Juvenile Justice caseworkers supervise the youth and monitor compliance with the rules of probation, orders of the court, and a supervision plan. After approval by the committing court and the department, the youth is discharged from probation.

FINDINGS

8. The department is not meeting probation and aftercare supervision requirements for youth who have been adjudicated delinquent

Finding

In addition to providing case management and services to children committed to its custody, the Department of Children's Services (DCS) also supervises youth who have been adjudicated delinquent but are not in its custody, through the probation and aftercare programs. Juvenile court judges assign the youth to DCS probation in lieu of committing the youth to the department's custody; also, youth are placed in the aftercare program as their custodial episode with the department ends. Our review focused on the adequacy of the supervision provided to the youth assigned to probation or aftercare. Supervision of these youth ensures the youth comply with the rules of probation, including consistent school attendance and regular drug screens, and improve their behavior. In order to identify whether the minimum level of contact (based on the youth's supervision level) was achieved, we examined the case file in the Tennessee Family and Child Tracking System (TFACTS) and interviewed the caseworker assigned the youth. Based on the results of that review, auditors have little assurance that the department's supervision of youth who have been adjudicated delinquent and are in the probation and aftercare programs is sufficient.

The department's policy specifies a minimum amount and frequency of particular contacts, depending on the supervision level assigned to the youth from the Youth Level of Service (YLS) assessment, as shown in Table 1. YLS is a standardized risk assessment that measures the likelihood of recidivism for youth who have been adjudicated delinquent and identifies their supervision and treatment needs.

Table 1 Minimum Monthly Contacts Required by DCS Probation and Aftercare Supervision Policy				
Supervision Level	**Face-to-Face (F-to-F) Contact With Youth**	**Contact with Primary Caretaker**	**Home Visit**	**Contact with Service Providers (all persons providing services to the youth and the family)**
Very High	4	1 F-to-F	1	2 Telephone Calls
High	3	1 F-to-F	1	1 Telephone Call
Moderate	2	1 F-To-F or Telephone	1	1 Telephone Call
Low	1	1 F-To-F or Telephone	1 Per Quarter	1 Telephone Call

Source: DCS Policy 13.1.

The audit team reviewed a sample of 32 cases of youth throughout the state who have been adjudicated delinquent, and who were in the probation or aftercare programs on February 15, 2013. The cases reviewed represented 162 months of department supervision.[11] The sample of cases was chosen randomly from lists of youth on probation or aftercare that were provided by the department. Overall, the department documented the minimum contacts for only 57 out of 162 months of supervision (35%) that we reviewed. When a caseworker does not maintain regular contact with a youth, the primary caretaker, or a service provider, the caseworker may not be able to determine when additional assistance is needed, which could eventually lead to a judge placing the youth into the department's custody.

The department's policy requires the caseworkers to document both the level of supervision and the required contacts in appropriate screens within the case file in TFACTS. Auditors concluded that the lack of documentation in these screens indicated that the caseworkers did not make the contacts required by the department's policy. Furthermore, when we questioned TFACTS users about problems they had encountered using the system (see Finding 5), the loss of probation or aftercare supervision information they had entered was not mentioned.

The probation and aftercare supervision policy also describes how and when the caseworker's supervisors should monitor the supervision of the youth. However, the screens within TFACTS that are supposed to be used to record probation or aftercare contacts do not have a way to indicate the supervisor has reviewed the recording. Considering the low rate at which our review found appropriate youth supervision to be occurring, it seems likely this supervisory monitoring is not occurring as prescribed by the policy.

[11] Our review of the documentation began in late March 2013; we reviewed case file documentation of activity that occurred from July 1, 2012, to February 28, 2013.

One observation the audit team made through our case review was that YLS assessments or reassessments were not done in a timely manner, or at all in several cases, to support the supervision level for probation or aftercare. In these cases, we relied on the caseworkers' statement of the supervision level for our review, even though there was no documentation to support their assertion. Nonetheless, the department's policy requires that a YLS assessment be completed when a youth is placed on DCS probation or prior to the youth's release from custody (i.e., when the youth is placed in the aftercare program).

Recommendation

The department should take steps to ensure that the caseworkers adequately supervise youth who have been adjudicated delinquent and are on probation and aftercare, and that they properly perform YLS assessments or reassessments according to departmental policy. These steps should include retraining on these policies for Juvenile Justice caseworkers. Additionally, these caseworkers should be adequately supervised and monitored by their team leaders and coordinators. The creation of management reports for probation and aftercare cases from TFACTS data will help make this monitoring more effective (see finding 5 for further discussion of this issue).

Management's Comment

We concur. Work has already begun on a report to show the timeliness of the completion of the Youth Level of Service/Case Management Inventory (YLS) for all delinquent cases. We have a preliminary report and are waiting for a final report to share with management staff in the region.

As a corrective action these issues will be put on the agenda for the Juvenile Justice Policy and Practice Workgroup. Recommendations will include:

- Verifying that case reviews are being conducted on these cases,
- Assuring TFACTS functionality supports documentation of the supervision level and approval by the supervisor,
- Monitoring the completion of the YLS along with ensuring supervision level is consistent with the score, and
- Recommending other reports that will assist supervisors in managing these cases

9. The department needs more residential treatment options to meet the needs of youth who have been adjudicated delinquent

Finding

The Department of Children's Services (DCS') Division of Juvenile Justice provides a range of services to youth that the juvenile courts have committed to the department for delinquent offenses. To assess the level of treatment resources available for youth who have been adjudicated delinquent, auditors randomly selected a sample of 5 of the 12 DCS regions and interviewed DCS staff responsible for placing those youth in custodial treatment within the 5 regions. The interviews revealed that DCS does not have sufficient treatment resources in all regions reviewed for youth who have been adjudicated delinquent. This lack of treatment resources has caused the department to place youth significantly far from their homes to receive needed treatment. Furthermore, it has contributed to treatment providers' ability to be selective in the types of youth they agree to serve and to youth sometimes remaining in detention facilities for extended periods. DCS staff responsible for network development is aware of the need for additional treatment resources and has plans to create a needs assessment for the regions; however, no formal needs assessment currently exists.

Several department employees we interviewed rated the placement options in their region as poor and stated that they did not have sufficient treatment options available locally. The specific treatment needs varied by region but, overall, staff consistently mentioned the following areas of deficiency: group homes; residential placements for females; alcohol and drug treatment; and level 3 residential treatment facilities (for youth with significant mental health issues and social and educational impairments). Some of the other resources found to be lacking in various regions were residential treatment placements for male and female sex offenders and placements for youth ages 18 and 19 years old.

Youth Often Must Receive Treatment More Than 75 Miles From Their Home

DCS policy 16.46 states that youth are to be placed in a manner that is respectful of a youth's home or school district and in the youth's own community. Specifically, the optimal range for residential treatment placement is within the region or within a 75-mile radius of the home where the youth entered custody. However, the policy is not consistently followed because of insufficient regional treatment resources. According to department employees, they consider the 75-mile requirement when placing youth but are more concerned with the youth receiving the treatment needed. Therefore, they are often forced to place youth more than 75 miles from their homes because the necessary treatment is not available locally. Several caseworkers gave examples of having to send some youth significant distances away for treatment. Being significant distances from their homes is difficult for youth and their parents, as well as for the caseworkers, who may have to travel hundreds of miles to visit youth. If the caseworkers are not approved for overnight travel, they must return home the same day, causing their visits to be limited.

Policy 16.46 allows for exceptions to placing youth within 75 miles of their home, such as placing the youth with a relative who lives outside the region or the youth's needs being "so

exceptional that they cannot be met by a family or facility within the region." However, placements more than 75 miles from youth's homes do not appear to be limited to those exceptions.

Insufficient Placements and Performance-based Contracts Contribute to Some Providers' Selectivity in the Types of Youth They Serve

By policy, private providers that contract with DCS to provide services must accept the youth who have been adjudicated delinquent who qualify for their treatment facilities. However, multiple DCS staff we interviewed stated that the private providers are being selective in the youth they admit. According to staff, the lack of available beds in some regions and performance-based contracts contribute to this selectivity. DCS contractors operate under a performance-based contract system; payments from the state are directly related to contractors' compliance with various performance objectives. The measures monitored include number of days in care, a permanent exit from state custody, and re-entry into state custody. Many providers stay at full capacity, so there are often waiting lists for youth needing placement. With multiple youth available to fill an empty bed, the private providers are likely to select the youth who would be the most successful in their treatment programs and the most likely to achieve a permanent exit from custody.

We interviewed some private provider staff, who confirmed that the current standards of the performance-based contracts encourage providers, especially the smaller providers, to be more selective. The providers also raised concerns regarding the baseline measurements that are used to grade their performance. Their primary complaint is that the baseline requirements need to be reassessed to reflect the reality that youth today need more services and higher levels of treatment. Additionally, providers believe that the performance-based contracts can sometimes focus more on the goals (e.g., moving youth out of treatment as quickly as possible) rather than what is best for the youth (e.g., longer, more intense treatment).

Some Youth Remain in Detention Facilities Longer Than 30 Days

According to Policy 16.46, youth should not remain in a detention facility longer than 30 days (until an assessment of the youth's needs is completed or a long-term placement is secured), and the facilities are meant only for delinquent youth requiring constant supervision due to the risk to the community or others. Although DCS staff stated they take extra efforts to ensure that youth stay in detention the least amount of time possible, several mentioned cases (usually youth requiring a secure placement or more intense treatment) when youth were in detention for over 30 days while awaiting placement in a treatment facility. Other staff interviewed had seen few instances recently of youth spending extended time in detention.

To understand why certain youth have extended placements in detention facilities, we reviewed a judgmental sample of eight case files for youth who had been in detention facilities for more than 30 days as of February 26, 2013, and four case files for youth who had been in and out of detention facilities. Six of these youth were in detention because of their risk to the community; however, the other five[12] youth were in detention awaiting an appropriate

[12] One case file was included erroneously in our sample because of a data glitch in TFACTS.

placement. In some cases when youth were in detention for extended periods of time, staff made efforts to bring needed treatment services, such as psychiatric treatment, to the detention facilities. To ensure youth are being appropriately and quickly placed out of detention facilities, the department has instituted various procedures, such as detention update reports and regional administrator approval when youth are in detention for over 14 days.

Recommendation

The department should conduct a needs assessment to determine residential treatment resources needed in the 12 regions to appropriately serve youth who have been adjudicated delinquent. Once the needs assessment is completed, network development staff should work with private providers and department management to determine how best to expand resources to provide youth the treatments, levels of placement, and security they need.

The department should also work with private providers to address concerns regarding the performance-based contract process. The baseline measurements should be evaluated, as should the relationship between performance-based contract standards and providers' selectivity when accepting youth for placement. The department should hold providers accountable for not accepting appropriate referrals.

Management's Comment

We concur. The department continues to identify and address additional placement and treatment resources needed for youth in foster care. As part of this effort, the department has begun to gather information in a formal needs assessment and to take appropriate steps to eliminate gaps in services in various regions.

- Between 2011 and 2013, all twelve DCS regions conducted a non-custodial service array assessment as part of the In Home Tennessee initiative. The regional assessments have provided valuable information about what services are available within specific communities and what services are needed.
- The "75 Mile Report" produced on a quarterly basis provides information about the number of children placed beyond 75 miles of their home, thereby highlighting residential needs. As a result of providing this information to private providers, an additional 32 Level 3 residential beds will be available in Cleveland and Elizabethtown, TN by March 2014 and an additional 64 Level 3 residential beds will be available in Roane County, TN in October 2014.
- Weekly census and network capacity reports are used to track trends in the types and levels of services utilized. Efforts are underway to automate this process.
- On a weekly basis, youth placed in Primary Treatment Centers and Detention facilities are reviewed to ensure timely and appropriate placement. A database is maintained to identify and track gaps in available services. Such gaps inform the department of service needs.

- Monthly utilization reviews are conducted by DCS regional and central office staff to identify any trends relative to the timeliness in appropriately moving children and youth from high levels of residential care to less restrictive placements appropriately.
- The Division of Network Development works closely with the Division of Permanency to ensure that DCS recruits and retains an adequate foster care network.
- Quarterly Grand Regional Cross-Functional meetings are conducted with private providers and DCS staff. These meetings provide a forum for exchanging information about regional foster care and residential placement service needs.

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10. The department does not calculate a recidivism rate and does not measure the effectiveness of custodial and non-custodial services provided to youth who have been adjudicated delinquent

Finding

While the department has made progress toward defining and calculating the recidivism rate for youth released from the department's custody after being adjudicated delinquent, additional measures are needed to determine the short- and long-term outcomes and the effectiveness of all of the services provided to these youth. Because of the lack of measures in place for this population, the department cannot demonstrate that the treatment and services provided to youth who have been adjudicated delinquent are working as intended.

Custodial Recidivism Rate

In the July 2010 Department of Children's Services (DCS') Division of Juvenile Justice performance audit, we recommended that the department establish and implement a method to measure recidivism. Since that audit was published, the department created a definition of recidivism as well as a method to collect and analyze data on youth who have been adjudicated delinquent, to determine the recidivism rate. The department's recidivism definition is the rate at which youth released from a youth development center (YDC) are re-adjudicated and returned to either DCS' custody or the adult courts system within two years from the release date.

Using the newly developed methodology, the department calculated a preliminary one-year recidivism rate for a group of youth released from a YDC in 2010. However, the calculation of the complete two-year rate has been put on hold as the department revisits the definition. The department, as well as the auditors, identified a weakness in the definition: most youth who have been adjudicated delinquent are not placed in a YDC while in DCS custody; therefore, a recidivism rate that only looks at youth exiting from a YDC includes only a subset of the delinquent population served by DCS (as of October 31, 2013, about 400 of 1,400 or 29%). The department plans to expand the recidivism definition to include in the sample of youth who have been adjudicated delinquent those placed at residential facilities, resource (foster) homes, and YDCs. The new definition will better reflect the effectiveness of the variety of treatments provided to these youth while in state custody.

Additional Short-term and Long-term Outcome and Effectiveness Measures

Recidivism, however, should not be the only measure the department uses to measure the juvenile justice system's performance, particularly since the results require significant time to pass. The National Center for Juvenile Justice states "to evaluate the system's performance chiefly in terms of recidivism . . . miss[es] other important measures of the system's day-to-day performance." Therefore, auditors reviewed best practices on juvenile justice performance measures to provide guidance to the department in developing additional measures. Additionally, we interviewed DCS Juvenile Justice caseworkers throughout the state to understand how these caseworkers informally monitor the effectiveness of treatment and services for individual youth.

Our review identified some measures that could be used to monitor the outcomes and effectiveness of custodial programs for youth who have been adjudicated delinquent.

- The number or percentage of youth exhibiting desired changes in behavior. Caseworkers interviewed said either the Child and Adolescent Needs and Strength (CANS) assessment scores or the Youth Level of Service (YLS) assessment could be used to quantitatively demonstrate behavioral changes over time. The CANS assessment is used for most children and youth in the department's custody, and the initial assessment (done at the beginning of the custodial episode) indicates the level of placement (i.e., level 1 to 4) needed. The YLS assessment is unique to the population of youth who have been adjudicated delinquent since it indicates the risk to re-offend. Both the CANS and YLS assessments are redone at certain intervals during the custodial episode. Some caseworkers we interviewed thought that the CANS and YLS assessments could be manipulated to show a reduction in score over time.
- The number or percentage of youth who completed the program's requirements.

The department currently also does not have a way to systematically measure the outcomes and effectiveness of its probation and aftercare programs. Both of these programs involve youth who have been adjudicated delinquent and are receiving non-custodial (in-home) services and treatment, as well as case management from DCS caseworkers. Our review of best practices and interviews with caseworkers suggested the following measures could be used to monitor the outcomes and effectiveness of probation and aftercare programs while the youth is in one of these programs. Some of these measures are similar to those measures that could be used for custodial programs, although how the department would define that measurement would differ.

- The number or percentage of youth on probation or aftercare exhibiting desired changes in behavior, demonstrated through the number of negative drug screenings, school attendance, school grades, or the change in YLS assessment scores.
- The number or percentage of youth who completed the program's requirements (i.e., the court order and the department's rules of probation) without being brought back to court.

- The number or percentage of youth committed or re-committed to DCS custody or the adult court system while under the program's supervision.
- The number or percentage of cases closed without a new arrest or adjudication.

Furthermore, because the department's current recidivism definition only includes youth who were adjudicated delinquent and have exited DCS custody, the department could benefit from a long-term effectiveness measure that only focuses on youth who have exited the probation supervision program and have returned to either DCS probation or to DCS custody.

Recommendation

The department should define, calculate, publish, and periodically update a custodial recidivism rate. In addition, the department should develop other effectiveness measures for youth who have been adjudicated delinquent and placed in DCS custody. Lastly, measures should be established to monitor the effectiveness of the probation and aftercare programs.

Management's Comment

We concur. The department needs to complete the process of defining and measuring both the custodial and noncustodial recidivism rate as they relate to positive youth outcomes, rather than as measures of failure. Currently, through TFACTS the department can obtain the number of youth who re-enter state custody; we intend to go further to examine recidivism by different groups, risk levels and rates over time through analysis of Standardized Program Evaluation Protocol scoring to learn more about the impact of programs and services currently in place. Before the findings of this audit report, the Division of Juvenile Justice had already committed to forming a collaborative, multi-disciplinary task force to develop a plan to implement a TN Division of Juvenile Justice initiative for reform. The task force is charged with reviewing current juvenile justice policies and practices, recommending changes where needed and moving the TN Division of Juvenile Justice toward a balanced approach philosophy emphasizing habilitation of delinquent youth by promoting accountability, ensuring competency development and community safety through a continuum of services, sanctions and incentives that have shown to be effective in reducing re-offending.

We propose to:

- Form a sub-committee of the Juvenile Justice Reform task force to standardize the population being tracked for recidivism, the action and data defining the recidivist and arriving at a consensus on a tracking period. The committee would be comprised of representatives from child serving agencies, child advocacy groups, Administrative Office of the Courts, DA's Office and Public Defender's Office to act in a consulting and advisory capacity.
- Make reducing statewide recidivism a department priority, establish baseline recidivism rates and set reduction goals

- Due to state budget constraints, focus services and treatment on youth who are most likely to recidivate.
- Establish practices and/or contract with programs that are based in science and address factors correlated with youth re-offending.
- Commit to not only collecting and compiling recidivism data, but analyzing it, discussing data findings and identifying areas that need improvement.

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11. The department has not yet ensured full compliance with the "evidence-based" law, and implementation has been inconsistent

Finding

Chapter 585, Public Acts of 2007 (codified as Section 37-5-121, *Tennessee Code Annotated)*, required the Department of Children's Services (DCS) to start a multi-year process of implementing practices and programs that have been scientifically proven, or are supported by research or theory, to reduce juvenile delinquency. The department was required to determine which of its current programs met the statutory requirements and report to the legislature no later than January 1, 2009. The department fulfilled that requirement and submitted the report *Progress Toward Evidence-Based Practices in DCS Funded Juvenile Justice Programs* to the legislature on December 31, 2008. The law further requires the department to ensure that for fiscal year 2012-2013 (and each fiscal year thereafter), 100% of the funds expended for delinquent juveniles (i.e., all delinquency programs) meet the statutory requirements for being evidence-based. However, since the submission of the initial report, implementation has been inconsistent, with gaps in implementation progress.

In order to measure the success of DCS's implementation of the "evidence-based law," auditors selected a sample of private providers serving youth who have been adjudicated delinquent in five randomly chosen DCS regions. We interviewed private-provider staff and reviewed documentation to determine their knowledge of the evidence-based law, as well as the amount of implementation assistance provided by DCS.

For the private providers interviewed, their understanding of the evidence-based law requirements and the level of related implementation assistance they received from DCS varied. Some providers, particularly those who had been actively involved with the department during the initial implementation, were fully aware of the evidence-based law and were able to provide examples of their compliance with evidence-based treatment programs. Other providers were not aware of the evidence-based law and had received little or no implementation assistance from the department.

Several providers mentioned a lack of communication with the department after staff involved in the initial implementation of the evidence-based law left DCS. Department staffing changes also delayed collection of program data and implementation progress. The law's

requirements include the establishment of a method for ongoing collection and evaluation of quantity and quality of treatment services provided to each youth. Although some providers reported sending program treatment data to the department, other providers stated they had sent such data in the past but stopped after their implementation team contact left the department. Both department staff and a contractor brought in to assist DCS with the evidence-based law implementation and analysis of the data verified the lack of consistent collection of program treatment data. According to the contractor and department staff, implementation progress essentially stopped for about a year when no department staff was assigned implementation coordination duties.

The evidence-based law requires service provider contracts to state that only evidence-based practices will be used. We found some evidence of compliance with this requirement. One of the newer contractors providing treatment to youth who have been adjudicated delinquent stated that their facility was in compliance with the evidence-based practices and that the request for proposal for the contract required that all treatments be evidence-based. This provider's contract has language that reflects the new evidence-based law and requires the contractor to cooperate with DCS in an evaluation of its services and to provide all information needed for that purpose.

After our private-provider review was completed, DCS decided to move forward with implementation of the evidence-based law. In June 2013, DCS staff contacted the private providers and requested that they submit all of their evidence-based treatment forms from January to June 2013. These forms document the specific types, frequencies, and duration of therapy the treatment providers conduct. Department staff and contractors review the forms to determine if the therapy qualifies as evidence-based treatment. Of the 26 providers contacted, 21 had submitted the forms as of mid-September 2013.

Although the department has clearly made progress since the initial passage of the law and has taken steps to move toward full implementation, there have been gaps and inconsistencies in implementation progress, and the department has not yet fully complied with the evidence-based law.

Recommendation

The department should work with all contracted private providers to continue implementation of the evidence-based law and should ensure that 100% of the funds expended for delinquent juveniles (i.e., all delinquency programs) meet the statutory requirements.

Management's Comment

We concur that the department has not yet ensured full compliance with the "evidence-based" law. The process of meeting full legislative compliance has been challenging for the Division of Juvenile Justice. Although an evaluation team from Vanderbilt University, Peabody Research Institute was brought in to handle the logistics of putting the "evidence-based" law into

action, the Division of Juvenile Justice, primarily funded by state dollars, faced budget cuts in 2012 that precipitated the loss of key staff involved in the initial design of the approach establishing the baseline of existing services, data collection submission and overall system improvement. The overall compliance process was divided into four phases:

Phase I: Program content identification
Phase II: Program dosage training and collection (Note: automation of data collection in this area is pending the roll out of TFACTS fields and tables designed for this purpose)
Phase III: Establishment of standardized program quality measures and complete scale up of juvenile risk assessment (YLS)
Phase IV: Automation and associated validity checks established for all key evidence-based data and Standardized Program Evaluation Protocol score analysis

Phases I and II have been completed and we are poised in calendar year 2014 to complete Phase III and prepare the infrastructure and processes needed for Phase IV.

We propose to:

- Continue to collect data from providers using a temporary collection format, until the data collection process can be automated. Note: Meetings have taken place with IT staff to define the data elements necessary to meet the requirements of the EBP statute.
- Develop next set of action steps needed to proceed with Phase III.
- Continue to monitor and validate the use of the YLS for all DJJ juveniles in the state.
- Utilize the Standardized Program Evaluation Protocol tool to evaluate and enhance existing programs currently delivered to youth involved in the juvenile justice system using evidence informed and validated protocol.

Effective September 2013, a licensed doctoral level mental health clinician joined the Network Development unit as the Director of Network Services A significant part of his role is to regularly visit and communicate with the private providers who contract with DCS to evaluate and track their implementation of evidence-based practices and treatments. This includes providers that serve youth who have been adjudicated delinquent. The Director of Network Services will offer some limited technical assistance to providers and serve as a liaison to additional resources (e.g., Centers of Excellence) that can support providers' efforts to consistently and effectively implement evidence-based practices.

OBSERVATIONS AND COMMENTS

The topics discussed below did not warrant a finding but are included in this report because of their effect on the operations of the department and on the citizens of Tennessee.

Additional Capacity of Non-custodial Services Is Needed for Youth Who Have Been Adjudicated Delinquent

According to juvenile court judges and department Juvenile Justice caseworkers, the availability of non-custodial (in-home) services and treatment for youth who have been adjudicated delinquent is acceptable throughout the state but additional capacity is needed to better serve the children and their families. In-home services provided by the department and community partners assist children and their families to minimize the risk of children coming into custody and to increase safety and family permanence. For the population of youth who have been adjudicated delinquent, these services are usually provided because the youth is placed on probation by the court. These services are also provided to children returning home after a custodial episode (i.e., aftercare).

Overall, a majority of Juvenile Justice caseworkers the auditors interviewed reported that they believed the availability of in-home services was average; in other words, the array of services available "were standard" but some options were missing. Juvenile court judges throughout the state who responded to the auditor's survey[13] felt similarly about the availability of treatment services in their region. Approximately 39% of these judges were satisfied with the services available.

However, 71% of the judges who responded stated that they have committed a child into the department's custody because of the lack of treatment options available in their region. One judge noted that in several cases he had committed children to the department's custody to obtain the appropriate treatment since it did not exist in the area. Another judge stated that if she becomes aware that needed services are unavailable or delayed, she is more willing to place a child in custody so the services are provided more quickly. A few caseworkers we interviewed mentioned some cases when the youth could not get the necessary services in their region, and the judge committed the child to custody just to ensure they would receive proper treatment.

The Juvenile Justice caseworkers identified certain service types that are most needed for the youth who have been adjudicated delinquent: substance abuse treatment, mental health treatment, and sexual offender counseling. Judges we surveyed most commonly selected intensive family preservation, outpatient substance abuse, outpatient mental health, and parenting education as the in-home services most needed in their region.

The department is already taking steps to strengthen and improve in-home services throughout Tennessee. Starting in 2009, the department implemented the In-Home Tennessee

[13] We invited all 159 juvenile court judges and magistrates to participate in our online survey during April 2013, 38 of whom (24%) responded (8 from West Tennessee, 16 from Middle Tennessee, and 14 from East Tennessee).

initiative to increase access to in-home services in all of the department's regions. Each region assessed its access to and capacity of various in-home services.

The regions' assessment results were generally consistent with the information auditors received from the caseworkers and judges. The majority of regions report that less than 50% of their population can easily access outpatient substance abuse and intensive family preservation services. The assessment also found that about half of regions indicated there was insufficient capacity (i.e., less than 50% of the demand could be met) for outpatient substance abuse, outpatient mental health, and parenting education services.

The department is currently implementing strategies to enhance the delivery of in-home services. Each region will identify key areas for improvement based on the assessment results and will develop a "Resource and Capacity Development Plan" to make improvements in these areas. The goals outlined in the plan, according to the department, should address reforming current department practices to enhance service provision and achieve desired outcomes, or possibly creating new services.

The Department's Division of Juvenile Justice Is Reviewing How to More Effectively Allocate Juvenile Justice Prevention Grant Funds

Each year, the Department of Children's Services (DCS) Division of Juvenile Justice provides 31 grants of state funds to county juvenile courts or non-profit organizations, with the goal to prevent children from entering or re-entering DCS custody. For fiscal year 2012-2013, the grant funds totaled $4.83 million. Table 2 on page shows the grant service types, grant recipients, and grant amount.

Each grant recipient uses the funds in ways that support their community's needs and that work toward preventing children from entering DCS custody. Auditors reviewed 10 of 31 grant proposals submitted to the department from all Juvenile Justice grant programs and service types to determine the various services the grantees provide to their communities.

All Community Intervention Services grants are used for intensive probation services that monitor youth referred by the juvenile court who are at risk for commitment to state custody. Intensive probation involves case management by program employees, home and school visits, drug screenings, and referrals to treatment and counseling. Aftercare grants provide support to youth who have been adjudicated delinquent and are exiting DCS custody, in the form of face-to-face contacts with the youth and family, referrals to individual and group counseling, alcohol and drug screenings, and parent group meetings.

Table 2 Fiscal Year 2012-2013 Juvenile Justice Grants			
Program	**Service Type**	**Grant Recipient**	**Amount**
Community Intervention Services	Intensive Probation	East Tennessee Human Resource Agency	$146,712
	Intensive Probation	Helen Ross McNabb Center	$266,782
	Intensive Probation	Putnam County	$65,656
	Intensive Probation	Rutherford County Juvenile Court	$46,448
	Intensive Probation	Southeast Human Resource Agency	$101,064
	Intensive Probation	Sullivan County	$57,494
	Intensive Probation	Upper Cumberland Human Resource Agency	$191,418
	Community Intervention Services Grants Subtotal		**$875,574**
Juvenile Court Prevention	Custody Prevention	Alamo Board of Education	$54,817
	Custody Prevention	Benton County Juvenile Court	$92,617
	Custody Prevention	Blount County Juvenile Court	$98,668
	Custody Prevention	Bradley County Juvenile Court	$66,581
	Custody Prevention	Carroll County Juvenile Court	$643,884
	Custody Prevention	Crockett County Schools	$68,520
	Custody Prevention	Knox County Juvenile Court	$183,392
	Custody Prevention	Montgomery County Juvenile Court	$422,082
	Custody Prevention	Rutherford County Juvenile Court	$417,696
	Custody Prevention	Tipton County Juvenile Court	$343,970
	Custody Prevention	Weakley County Juvenile Court	$62,747
	Child & Family Intervention	Davidson County Juvenile Court	$434,333
	Child & Family Intervention	Madison County Juvenile Court	$135,375
	Child & Family Intervention	Montgomery County Juvenile Court	$70,929
	Child & Family Intervention	Shelby County Juvenile Court	$67,688
	Child & Family Intervention	Stewart County Juvenile Court	$14,607
	Truancy Prevention	Decatur County Juvenile Court	$54,817
	Truancy Prevention	Dyersburg City Schools	$68,520
	Truancy Prevention	Henry County Board of Education	$48,917
	Truancy Prevention	Lauderdale County Juvenile Court	$68,571
	Truancy Prevention	Sullivan County Juvenile Court	$53,720
	After School Program	Socially Yours for Youth, Incorporated	$34,622
	Juvenile Court Prevention Grants Subtotal		**$3,507,073**
Aftercare	Intensive Aftercare	Helen Ross McNabb Center	$296,493
	Intensive Aftercare	Quinco Mental Health Center	$148,208
	Aftercare Grants Subtotal		**$444,701**

Source: Program Documentation.

Juvenile Court Prevention grants have several sub-types, as listed in Table x, though many communities use the grant funds in similar ways. Recipients provide direct services or programs to children and their families, such as individual and group counseling; parental education or support; GED preparation classes; tutoring; and after-school or extracurricular activities. Other recipients use the funds to help pay the salary of youth service officers or truancy specialists. One county (Carroll County) uses the funds to maintain Carroll Academy, a day treatment facility focusing on custody prevention and increased academic skills.

The Division of Juvenile Justice monitors the recipients of the reimbursement grants in several ways. The program manager receives invoices for review and approval, then submits them to the fiscal office for payment. Grant recipients are required to submit monthly program and outcome data, such as the number of children being served, the number of children discharged from the program successfully, and the number of children committed to state custody. Grant recipients are also required to submit an annual report at the end of each grant period.

These grant recipients have received the funds without going through an open grant proposal process for many years, according to program personnel. However, the department is reviewing the grant allocation process and anticipates changing the process for fiscal year 2014-2015.

DIVISION OF CHILD PROGRAMS

BACKGROUND

The Department of Children's Services' Division of Child Programs, created in April 2013, is responsible for providing in-home services, foster care, and adoption to children who are at risk of being removed, or who have been removed, from their homes because of child abuse or neglect.

Objectives

The objectives covered in this chapter were to

1. determine and assess the process of placing youth in resource (foster) homes and other out-of-home care;
2. determine and assess the process for recruiting resource homes;
3. determine if the department intends to continue Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screenings in light of the John B. lawsuit exit and, if so, to determine and assess how the department ensures these screenings occur;
4. determine and assess how the department monitors whether caseworkers comply with visitation requirement for children in out-of-home care;
5. determine the extent to which the department expanded its foster care program and how children in the extended program are monitored; and
6. determine and assess the process used to screen and otherwise intake new resource parents.

Organization and Functions

The Division of Child Programs is organized into three units: permanency/in home/out of home services; regional administrators; and network development. The Deputy Commissioner for Child Programs, who reports directly to the Commissioner, oversees the division.

The ***permanency/in home/out of home services*** unit, as well as the local family caseworkers who report to the ***regional administrators***, provide services to children to achieve safe permanency, whether they are in their original home or have been removed. Specialized assessment tools and Child and Family Team Meetings are used to identify the child's needs and the optimal care situation. If a child can safely remain in the home, the department can provide services or help the family access a variety of services, such as drug treatment. When a child must be removed from the home, the department prefers to place the child with a family member as long as that person can safely care for the child.

To achieve permanency, the department uses dual planning, meaning each child in custody has two plans being filled simultaneously—one for what is needed for them to return home and one for freeing the child for adoption. Services are provided through department-contracted resource homes and private providers. The ***permanency/in home/out of home services*** unit also works to find and support adoptive parents.

The ***network development*** unit works with contractors who provide child placements and services, specifically level 2 service providers (specialized foster care and group homes), level 3 service providers (high-level residential resource homes capable of handling significant mental health disorders), and level 4 service providers (residential care/hospital-based). Network development also identifies service gaps or shortages and recruits private providers to fill those shortages. Finally, the unit is responsible for the department's performance-based contracting approach, which rewards private service providers/contractors for patient outcomes, rather than simply for the number of services they provide.

FINDINGS

12. The department needs to further assess foster care placement needs and monitor private provider placement practices

Finding

The department places children into foster care, depending on the child's needs, in a department or contract agency resource (foster) home or in placements that provide higher levels of care and/or a more restrictive environment. Auditors' review found that the department has appropriate processes in place to recruit and approve resource homes (see pages 80 and 86). However, department caseworkers report difficulties in placing certain types of children in the most appropriate settings, which could result in some children's needs not being fully met. Some private providers' selectivity—declining to accept children they believe will be difficult to treat or manage—can also impact placement. A formal needs assessment for the department's

regions could help the department effectively focus its efforts to develop additional placement and treatment capacity. Department management stated there are plans to create a needs assessment for the regions, but no formal needs assessment currently exists.

Placement Process

Whenever the department removes children from homes for their protection, the department requires caseworkers to assess each child's unique needs and place the child in the most appropriate setting to meet those needs. According to the department's policy, the placement is to be "respectful of the child/youth's home/school district, in their own community, with siblings, in a home-like, least restrictive setting that will meet their unique needs." All placement decisions are made in the context of a Child and Family Team Meeting, if possible. The development of the team meeting begins when there is any risk that a child may be removed from his or her home. The team is convened to explore the safety and risk issues; to assess how to meet the child's needs for safety in the least restrictive, least intrusive manner possible; and to examine whether there are other family members that can care for the child. The team also ensures that the specific placement is appropriate to meet the child's needs, that the resource parents or other providers have the information they need to care for the child; and that a visitation schedule is arranged with the family.

The child's needs are identified by completing formal assessment tools, including the Child and Adolescent Needs and Strengths assessment, Family Advocacy Support Tool manual, Structured Decision Making, Youth Level of Service assessment, and health assessments. These tools are used to inform caseworkers of the child's needs and help to identify proper placement.[14] Whenever possible, it is preferable to place a child with a relative. However, if that is not an option, a child will be placed in one of four different level placements, depending on the level of care the child needs. The least restrictive placement, a level 1 resource home, is most appropriate for children who display no more than mild to moderate behavioral issues. A level 2 contract agency is a specialized resource or group home for children with mild to moderate behavioral or mental health issues who need a higher level of care. A level 3 residential treatment center is for children who display significant mental health disorders. Level 4 placements are residential/hospital-based care for children experiencing delusions, hallucinations, or serious impairments in communication. These children require 24-hour supervision or access to staff.

Lack of Appropriate Placements

Interviews with a sample of 24 child placement caseworkers randomly selected from across the state consistently revealed that caseworkers sometimes struggle to find appropriate placements for some children. For example, if a child is classified as level 1, but no level 1 home is available, then the child may be placed in a level 2 setting, where the child will be more restricted and will be receiving more services than needed. Additionally, the state would incur unnecessary costs for the higher level of care. On the other hand, if a child is classified as level 2, and no level 2 facilities are available or a provider will not accept the child, then the child may be sent to a level 1 home and may not receive the appropriate services and supervision.

[14] DCS Policies and Procedures 16.46, updated March 1, 2012, as of September 27, 2013.

Placement staff reported that the department needs more level 3 (residential care) and group home settings.

Similarly, department staff report that there is not always a less restrictive, more appropriate placement available for children who are ready to step down from a higher, more restrictive setting, especially stepping down from a level 3 to a level 2 placement. When this happens, the children may remain in their current placement until a more appropriate placement becomes available. This not only holds children in a more restrictive setting than they require, but it also takes beds away from those children that do need this particular type of placement.

Department management confirmed that there can sometimes be problems placing children with certain needs but that staff monitor the types of placement capacity needed by speaking with placement specialists; participating in weekly phone meetings with the regional offices; and discussing weekly placement reports, which show how many children are placed in what types of placements each week. Based on this information, the department's provider relations staff then work directly with providers to build additional capacity. As noted above, a needs assessment by region could help the department better formalize and target its efforts.

Some Private Providers Are Selective Regarding the Children They Accept

In addition to a general lack of capacity, placement staff across the state consistently reported that many private providers are selective in accepting children and discourage the placement of difficult-to-treat children in their care. Caseworkers reported that many providers simply do not want to deal with disruptive children, teenagers, and kids with sexual issues, even if they have vacant spots. When informally discouraged by the providers, local department placement staff often avoid a conflict with the provider and attempt to find a placement elsewhere.

Because they are paid for outcomes under performance-based contracting, providers have an incentive to be selective and to avoid serving children who may be less likely to have a positive, quick exit. The provider's performance within the performance-based contract is determined by criteria such as the number of child exits to permanency (i.e., exits intended to provide the child with a stable and permanent family reunification, guardianship, or adoption), out-of-home care days, and re-entries to out-of-home care after a successful exit to permanency.

The department's Private Provider Manual specifically states that "the provider MUST accept referrals that meet the criteria outlined in the scope of services. Determinations regarding the order of admission are subject to the discretion of DCS staff. Providers will be held accountable for refusing to accept appropriate referrals." However, if providers believe they received a child whose needs are not appropriate or not within their scope of services, there is a prescribed formal appeal process they can use. Department management responsible for network development is unaware of providers using this appeals process recently, which suggests providers may be denying services at a lower, informal level. Because department management may not be aware of providers informally denying appropriate placements for economic gain, they may not be in a position to address potential contract breaches.

Department management acknowledges that some providers may be selective concerning the children they are willing to accept but stated that these providers would receive fewer referrals in the future. Therefore, providers have an economic incentive to accept as many children as possible within their treatment capabilities. In response to auditors' inquiries, department management also reported that they are working with regional placement staff to better document informal denials. Improved monitoring of the placement process would help the department identify which providers are denying children most often, as well as which types of children are repeatedly being denied placement.

Recommendation

The department should continue identifying and addressing additional placements and treatment resources needed for youth in foster care. As part of this effort, the department should conduct a formal needs assessment for each region of the state and then work with private providers and advocacy and community groups to determine how best to meet the additional needs identified.

The department also needs to continue developing mechanisms to monitor providers who may be informally denying services to children for solely economic reasons, which is in violation of provider-department agreements. If the department determines that such informal denials are occurring frequently, it should take steps to enforce contract provisions that require providers to accept all reasonable placements.

Management's Comment

We concur. The department continues to identify and address additional placement and treatment resources needed for youth in foster care. As part of this effort, the department has begun to gather information as part of a formal needs assessment and to take appropriate steps to eliminate gaps in services in various regions.

- Between 2011 and 2013, all twelve DCS regions conducted a non-custodial service array assessment as part of the In Home Tennessee initiative. The regional assessments provided valuable information about what services are available within specific communities and what services are needed.
- The "75 Mile Report" produced on a quarterly basis provides information about the number of children placed beyond 75 miles of their home, thereby highlighting residential needs within the three grand regions of Tennessee. As a result of providing this information to private providers, an additional 32 Level 3 residential beds will be available in Cleveland and Elizabethtown, TN by March 2014 and an additional 64 Level 3 residential beds will be available in Roane County, TN in October 2014.
- Weekly census and network capacity reports are used to track trends in the types and levels of services utilized. Efforts are underway to automate this process.

- Monthly utilization reviews are conducted by DCS regional and central office staff to identify any trends relative to the timeliness in appropriately moving children and youth from high levels of residential care to less restrictive placements.
- The Division of Network Development works closely with the Division of Permanency to ensure that DCS recruits and retains an adequate foster care network.
- Quarterly Grand Regional Cross-Functional meetings are conducted with private providers and DCS staff. These meetings provide a forum for exchanging information about regional foster care and residential placement service needs.

The department continues to develop mechanisms to monitor the extent to which providers may be informally denying services to children for solely economic reasons. Such mechanisms include:

- A revised Placement Exception Report ("PER") which will be piloted in early 2014. Among other things, PER documents the need for placement in excess of 75 miles of a child's home. The revised report includes a section which documents attempts to place children and youth with providers. As data are gathered, trends may emerge with regard to specific providers' admission patterns.
- Effective September 2013, a licensed doctoral level mental health clinician joined the Network Development unit as the Director of Network Services. A significant part of this role is to regularly visit and communicate with the private providers who contract with DCS to evaluate and track their implementation of evidence-based practices and treatments. The database developed from the visits will be used in conjunction with data gathered from PER reports and other sources. The Director of Network Services will offer some limited technical assistance to providers and will also serve as a liaison to additional resources (e.g., Centers of Excellence) that can support providers' efforts to consistently and effectively implement evidence-based practices.
- The above referenced mechanisms will provide an objective basis for any discussions and potential action which might be needed with specific providers with regard to their admission patterns.

OBSERVATIONS AND COMMENTS

The topics discussed below did not warrant a finding but are included in this report because of their effect on the operations of the department and on the citizens of Tennessee.

The Department Uses Reasonable Approaches to Recruit Resource Parents

Because resource homes, commonly referred to as foster homes, serve such an important role in caring for children in the department's custody, the Department of Children's Services

(DCS) and its private contractors use multiple techniques to recruit new resource homes. In addition to directly reaching out to potential resource parents based on the department's annual regional plans, the department and private providers rely heavily on existing resource parents to recruit new resource parents, which is consistent with best practice literature. As a result, the department's and its private providers' relationships with foster parents, which an advocacy group representative reported is fundamentally positive, is critical to future recruiting success and to maintaining existing homes.

Based on the department's fiscal year 2012 annual report, over 3,600 children (44%) of all the children receiving department services live in department or private-provider resource homes, so it is critical that DCS recruits enough quality resource homes to meet its needs on an ongoing basis. As resource families adopt children and/or no longer can or wish to care for children, there is an ongoing need to recruit new homes. DCS' official policies acknowledge the importance of recruiting and maintaining a diverse pool of approved resource families and ensuring that quality family home placements will be available to children in DCS custody.[15]

Resource Home Recruitment Guided by Annual Regional Recruitment Plans

The department appears to follow most of its policies for developing its annual resource homes recruitment plans. Under DCS policy, each region maintains a regional recruitment plan that is updated annually. These plans list the strategies each region will use for the following year, such as community strategies, home study strategies, linguistic barriers strategies, kinship care strategies, and retention strategies. Strategies may include requesting recruitment assistance from community partners and the faith-based community; using Facebook to disseminate recruitment information; holding annual foster parent appreciation events; identifying foster teens and their foster parents to share their experiences; and providing additional training and professional support to resource parents who are willing to take difficult teens. Strategies and action steps to retain existing resource parents are also required in each plan.

See the exhibit on page 83 for an example of information from a regional recruitment plan. Based on our review of each region's recruitment plan, the plans meet most of the department's standards. However, the department needs to update its official policies to reflect the deadline for regions to submit their annual plans to the department's central office. The department's policy states that each region should develop and submit a regional recruitment plan to the department's central office by January 15 of each fiscal year, but central office management currently requires regions to submit their plans by July 1 annually. In order to reduce confusion and ensure compliance, the department needs to update its policy to reflect that the annual regional plans are to be submitted by July 1.

In addition to generally meeting the department's policy, the recruitment plans' contents are appropriate in that they generally reflect the department's resource home needs and recommended best practices. As reported on page 77, auditors interviewed a sample of placement specialists from across the state to identify what types of resource homes and other placements they struggle to find for children removed from their home. The regional plans' contents appear to respond to those reported needs. In addition, auditors compared the regional

[15] DCS Policies and Procedures: 16.7, updated September 30, 2010, as of September 27, 2013.

recruitment plans to the needs expressed in interviews with regional placement specialists and team leaders. Auditors determined that the plans appear to support these needs. For example, a regional placement specialist reported that her region struggles to place children in resource homes that can serve sibling groups. The recruitment plan for that specialist's region includes approaches to recruit homes that will accept multiple siblings.

Department Relationships With Existing Resource Homes Are Key to Recruitment

Best practice literature and department experience suggests that existing resource parents are key recruiters. Private providers also report that existing resource families are the best tools in recruiting new parents. Some private providers even offer monetary incentives to families that recruit other resource parents. Therefore, the department's and private providers' relationships with existing resource homes, especially as it relates to recruiting, are critical to the department's success.

A representative from a foster parent advocacy group reported being satisfied with DCS and its recruiting efforts and having a very positive relationship overall with the department. The group representative stated she did not think there was much more the department could do to effectively recruit or retain foster homes.

It appears that the department implements recognized best practices into its recruitment efforts. It was evident from our review that many best practice guidelines consistently appeared within the regional recruitment plans.

Early and Periodic Screening, Diagnosis, and Treatment Screenings Continue After John B. Lawsuit Ended

In 1998, the Tennessee Justice Center filed the John B. lawsuit against the state on behalf of all children enrolled in TennCare, including children in department custody. The lawsuit alleged that children were not receiving appropriate health care. The state settled the lawsuit by entering into a consent decree to provide specific Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screenings and services. In March 2013, the Circuit Court of Appeals upheld an earlier district court ruling which stated that "the State has achieved a screening rate for children in DCS custody in excess of 95% and has demonstrated that it took all actions which could reasonably be expected under the circumstances to achieve a 100% screening rate." As a result, the state is now considered to have exited from the lawsuit.

Example from a Regional Resource Home Recruitment Plan

Summary of the Current Regional Needs and Priorities

In order to maintain a mutually beneficial relationship between RPS* and the resource homes, RPS will start holding meetings at the 9 month mark of no children being placed in the home. These are the homes that have repeatedly refused placements. At each quarterly visit, staff will discuss with the home any potential barriers to accepting a placement. Team leader and worker will have a home visit to discuss placements after 9 month period. The worker will encourage resource parents and will help facilitate support services such as becoming members of the Foster Parent Association and meeting with other resource parents in their area. Success in this area will be demonstrated by fewer empty homes reflected in the resource home report in TFACTS. This goal was established last year, but we feel that in order to see a real change, it will need to be in place for a longer period of time.

Increase the number of resource homes that are willing to accept teenagers. RPS workers will encourage resource homes to take teens. RPS will be actively involved in the respite process in which resource parents may take teens on a respite basis to help in their consideration of taking the placement of teens. The local Foster Parent Association will hold youth panels at one of their monthly meetings in which resource parents who have teens placed in their home will bring them to these meetings. RPS will invite the Independent Living Specialist to PATH Panels and at least one monthly Foster Parent Association meeting. Meet with the resource homes that take teens and discuss with them ideas of how to recruit other homes that would be willing to take teens. Success in this area will be demonstrated by an increase in homes that will accept teens as reflected in the resource home report in TFACTS. Due to the continued need for resource homes for our teen population, this goal remains on going. The region will demonstrate retention of resource homes by maintaining no less than 200 active homes at any given time. This will be demonstrated by the numbers of approved homes in the Resource Home Mega Report.

Improve communication between RPS workers and the Family Service Worker (FSW) worker to help ensure that the appropriate services are placed in the home in a timely manner to help prevent the disruption of a placement. Success in this area will be demonstrated by fewer placement moves, as tracked by data reports. RPS will attend all Child and Family Team Meetings as it relates to placement stability. The Regional Full Time Facilitators will prompt FSWs to include RPS in their invitations to all placement stability meetings involving a DCS home. This will be measured by a decrease in our moves as shown on the TFACTS moves report.

Summary of Regions General, Targeted and Child Specific Recruitment Efforts

The region has placed great emphasis on partnering with our resource parents, as we understand that they are in the best position to recruit new resource parents. This is why we have the monthly resource parent Continuous Quality Improvement that moves throughout the region, so that each county has an opportunity to host. This gives all resource parents a chance to come and interact with regional staff, and assist us in making improvements. Although we partner within our communities for special events, and attend regular community meetings to demonstrate a regular presence, we know that the most successful recruitment comes from resource parents that have positive experiences with the department. We are realistic in presenting the regional needs, the need for more teen homes and homes that can take large sibling groups. When homes come through that are only interested in taking one small child, the RPS team does a good job of explaining the realities of the department, and that we serve more clients than just babies. Our region works extremely hard in identifying relatives that are appropriate for placement of our clients, as we understand the importance of lessening the impact of trauma when a client is removed from their home.

*RPS – Resource Parent Support (DCS staff).

Despite exiting the lawsuit, the department continues to ensure children receive needed medical and dental treatment. Specifically, the department continues to monitor whether children entering department custody receive the following EPSDT screenings:

- comprehensive health and development history review;
- comprehensive unclothed physical exam;
- age-appropriate immunizations;
- age-appropriate lab tests;
- health education;
- vision screening; and
- hearing screening.

Since the lawsuit's exit, the department has not substantially changed its internal policy requirements that all children entering department custody must receive an initial screening conducted by the local health department within 30 days of entering custody. Subsequent screenings must be completed according to a schedule recommended by the American Academy of Pediatrics. For example, children ages three and older receive annual screenings, while younger children receive more frequent screenings. A regional well-being nurse is required to review the screening results to confirm that the screening included all the required elements and to identify any results requiring additional primary care follow-up. The child's caseworker is expected to arrange for any required follow-up care.

The department tracks EPSDT screenings through its centralized computer system, the Tennessee Family and Child Tracking System, which weekly generates reports showing every child's screening status and those children who will soon be due, or are overdue, for a screening. These reports are distributed to regional managers and supervisors, as well as private providers, who follow up on any overdue screenings.

Management Cannot Easily Monitor Case Manager Visits with Foster Care Children During the First Two Months of Custody

Under the July 2011 Brian A. v. Bill Haslam Modified Settlement Agreement and Exit Plan (the Brian A. agreement), department personnel or private providers are required to visit children in department custody at several intervals. For example, department protocol[16] requires department staff to visit children who are placed at a department facility or resource home

- within 72 hours of any new placement;
- no less than six times during the first two months in a new placement, at least half of which must occur in the placement setting;

[16] Department of Children's Services Visitation Protocol Attachment to Policy 16.38.

- two times per month after the first two months in a new placement, at least one of which must occur in the child's resource home or residential placement; and
- additionally, as needed based on assessment results or as recommended by supervisors.

All visits must include a private meeting between department personnel and the child (except when the child is an infant), away from the resource parent or caregiver. Additionally, at least half of the monthly visits should occur in the children's placement location, such as the resource home.

The department's compliance with these visitation requirements is monitored using several methods. First, the Brian A. Technical Assistance Committee (child welfare experts appointed by the court to assist the state in implementing the Brian A. agreement) monitors and reports on the department's progress in meeting the agreement. The committee's June 18, 2013, monitoring report found that in March 2013, 85% of children received two or more visits by a department-employed case manager, 14% received one visit by a department case manager, and 1% of children received no visits from a department case manager.

Second, the department regularly generates reports from its centralized case management tracking system, the Tennessee Family and Child Tracking System (TFACTS). However, these reports are limited. For example, regional managers receive and/or can access reports showing case managers visitation status. For children who have been in custody more than two months, managers can access these reports for the past 30 days, the past 45 days, and past two months. However, department staff currently do not have access to regularly generated TFACTS reports regarding children who have been in custody less than two months. Department management states that such reports have been difficult to program but are in the process of being developed. Although specially programmed reports covering children's first two months in custody have been generated and provided to the Technical Assistance Committee, they are not yet widely available for department personnel.

There are also no TFACTS reports monitoring whether a case manager visited privately with any child, whether they have been in placement less than or more than two months. Case managers are expected to enter this information into a note field within TFACTS. Therefore, their supervisors must manually check the child's record and read the narrative note to ensure the case manager recorded that the private visitation occurred. The Technical Assistance Committee reports that it is working with the department to develop a tracking mechanism to monitor private time contact within visits.

RESULTS OF OTHER AUDIT WORK

The Department Extended Foster Care Services in 2012

In response to the federal Fostering Connections to Success and Increasing Adoptions Act of 2008 and Tennessee's Transitioning Youth Empowerment Act of 2010, the Department of Children's Services extended foster care services effective July 2012 to qualifying young adults ages 18 to 21 who voluntarily agree to accept services. The main purpose is to help young adults leaving department care to transition into adulthood and gain the skills, knowledge, experience, and support necessary to obtain education, housing, employment, health services, and permanent supportive relationships. Youth can either stay in services at age 18 or return to services, if they have left, up to age 21. In order to receive services, youth must be completing high school or an equivalency program, be enrolled in college or a vocational program, or be unable to do so because of a medical condition.

Benefits available to participating young adults include education and training vouchers (up to $5,000 per year); placement supports; independent living allowances; wrap services (e.g., graduation fees and extracurricular expenses); skills classes; and support from staff members to help in achieving goals. Young adults who receive extended services and support must sign an agreement to participate in the program; to work with the Child and Family Team to create and follow a transition plan and to reach their goals; to meet monthly with a family service worker; and to attend a court hearing or administrative review every six months. The department's independent living program specialists oversee funding provided to young adults, track their participation, and monitor their eligibility. This and other information is reported monthly to the department's central office.

According to the department, 564 young adults received extension of foster care services during fiscal year 2013.

Process for Screening State and Private-Provider Resource Homes

Because resource homes, often referred to as foster homes, care for vulnerable children in private home settings, the department needs to ensure that these homes are carefully screened. Resource homes either work directly with the department or serve as a subcontractor for private providers. The department's requirements are the same for resource home applicants who apply through the department or a private provider.

The department requires prospective resource parents to be

- 21 years of age, unless the person is applying to be a resource parent for a sibling or other relative (in which case the applicant must be at least 18 years old);
- a legal Tennessee resident for at least six months;
- a United States citizen or a legal permanent resident; and

- in sufficient good health.

Resource parents may be single or married, with or without children of their own, able to financially meet their own needs (regardless of whether employed or not), and are to be considered regardless of their gender, race, color, or national origin.

Among other requirements, prospective resource parents must

- Complete a home study including interviews of all adults living in the home, a physical inspection of the home for safety and sufficiency, review of required medical reports, review of references, and verification of vehicle and other types of licenses.
- Pass background and other similar checks.
- Attend training. The department must offer this training, called Parents as Tender Healers (PATH), at least once per month. Private providers must provide this training as often as needed to maintain a sufficient pool of approved homes to fulfill their contractual obligations to the department. PATH training covers topics such as the application process, understanding the child welfare process, trauma impacts on children, cultural awareness, effective discipline, first aid, and medication administration. Approved resource homes must also receive ongoing training in subsequent years.

When resource homes apply to work directly with the department, as opposed to a private provider, the department's regional home study staff who has been working with the family recommends to approve or deny the application. That recommendation, along with the home's file, are then reviewed for approval or denial by the staff's supervisor and team coordinator. Private providers similarly submit their resource home applicants' files to the department for two levels of supervisory review and approval. In addition, the department's central office reviews all potential homes to ensure they meet federal funding requirements.

RECOMMENDATIONS

LEGISLATIVE

This performance audit identified the following areas in which the General Assembly may wish to consider statutory changes to improve the efficiency and effectiveness of the Department of Children's Services' operations.

Divisions of Child Safety and Child Health

1. The General Assembly may wish to consider deleting or amending statutory reporting requirements associated with the multi-level response system prior to completion of statewide implementation, including Sections 37-1-406(m)(1)(g)(2), 37-5-603(b), and 37-5-605, *Tennessee Code Annotated*.

2. The General Assembly may wish to consider addressing variations in the terms used to describe the department's process of administratively finding that a perpetrator has committed child abuse or neglect, by changing the statutory language to be more consistent.

ADMINISTRATIVE

The Department of Children's Services should address the following areas to improve the efficiency and effectiveness of its operations.

Divisions of Child Safety and Child Health

1. Department officials should ensure that all investigations are consistently and thoroughly conducted and documented and are subject to supervisory review in the Tennessee Family and Child Tracking System (TFACTS), with paper storage reserved for only those isolated types of documentation that are currently problematic for TFACTS. The department should also continue to identify and address such TFACTS documentation storage problems and, as they are resolved, ensure case managers are notified that all future documentation should be maintained in TFACTS.

2. Results of internal case file reviews should be aggregated, tracked, and analyzed to identify recurring and current investigation weaknesses. This information should be used to improve training and policy and procedure updates.

3. The department should insist that all Child Protective Investigative Teams (CPITs) act in a consistent and effective manner by ensuring all team coordinators send

invitations or notices to all team members about all events and by ensuring all department caseworkers bring cases to the teams during the active investigation phase rather than using teams as a simple check-off. Teams coordinated by non-center personnel should conduct the same surveys/self-evaluations conducted by child advocacy centers. Additionally, the department should use its new case manager training, statewide CPIT advisory board, and community relations analyst to reinforce the intended purpose and use of CPITs, as well as to encourage attendance from all statutorily required team members.

4. The department also should improve communications with the CPITs by developing methods to update teams operated by child advocacy centers about cases no longer requiring a CPIT meeting, such as updating NCAtrak; ensuring that the department's security certificate remains current; and continuing to work to fix the problem that may have resulted in some potentially qualifying cases not automatically referring to centers. The department should also develop a process to reconcile cases received by the Child Abuse Hotline that qualify for the CPIT process with the cases received by the teams.

5. The department needs to improve its tracking of child abuse and neglect referrals received by Internet, fax, and mail so that discrepancies are detected, analyzed, and addressed. Specifically, the department could consider providing additional training to hotline staff on the fax, Internet, and mail referral handling process, including the importance of correctly entering receipt dates into the manual tracking spreadsheet. The department could also institute a regular, frequently scheduled reconciliation between the manual tracking spreadsheet and TFACTS to identify any potential handling problems for follow-up.

6. The department should comply with mandates to provide information to the General Assembly, in accordance with the statutory sections below.

    - Section 37-2-205(f)(3), *Tennessee Code Annotated*, by providing a report to the Senate Judiciary Committee and the House Civil Justice Committee on county commitment data for the previous calendar year and a description of steps taken as part of a collaborative planning process regarding juvenile detention in county facilities.
    - Section 37-3-501(e), *Tennessee Code Annotated*, by working with the Department of Health and other departments that administer services to children and families to jointly report, at least annually, on or before December 31, to the Senate Judiciary Committee and the House Civil Justice Committee concerning administration of the Tennessee informational clearinghouse on teenage pregnancy. Alternatively, if the department, the Department of Health, and other impacted state agencies would like to suspend the clearinghouse's operations and this associated reporting requirement, they should propose legislation either eliminating or amending clearinghouse operations and the resulting reporting.

- Section 37-3-604, *Tennessee Code Annotated*, by annually reporting, on or before December 31 of each year, all specified information about the family preservation and support services to the Governor; the chairs of the Senate Health and Welfare and Judiciary Committees; and the chair of the House Civil Justice Committee.
- Section 37-5-105(4), *Tennessee Code Annotated*, by annually reporting all required elements in its annual report to all members of the General Assembly and specified other parties by January 31 of every year.
- Section 37-5-124, *Tennessee Code Annotated*, by continuing to report statutorily specified child deaths and near deaths within 10 days to the senator and representative for the child's legislative district.
- Section 37-5-128, *Tennessee Code Annotated*, by requesting to appear before the Senate Judiciary Committee and the House Civil Justice Committee by March 1 of each year for a review of departmental policies and protocols. Alternatively, the General Assembly may wish to consider amending this statute to remove the reporting requirement.
- Sections 37-1-603(a), (b)(1)(B), and (c)(2), *Tennessee Code Annotated*, by providing a direct opportunity for childcare centers and local school boards to participate in the development of a comprehensive state plan regarding child sexual abuse.

7. If the department reissues its annual report or other similar reports, as it did to comply with Section 37-5-519, *Tennessee Code Annotated*, it should notify all parties who received the original report, as well as clearly note in the report and on the department's website, that the report has been revised.

Administrative Functions

8. The Department of Children's Services needs to improve TFACTS' reporting quality and accuracy of data by identifying which important data fields lack sufficient validation features and then adding those features. User training on data entry fields should be improved to ensure users enter data into the correct field. The department should also continue efforts to make operational reports, such as reports on caseworker caseloads and on non-custodial juvenile justice cases.

9. The department should continue to improve users' abilities to search for existing records in TFACTS. Changes should be suitable for users' needs and correctly executed, and the department should determine whether the in-house development team or Compuware would be the best choice for implementing the changes.

10. The department should proceed with its plans to reduce the cumbersomeness of TFACTS. The department should complete projects to enable users to more easily navigate throughout the system and to interact with TFACTS using a more efficient user interface.

11. The department should continue to identify and correct areas within TFACTS that are experiencing issues with slow speeds or unexpected log-outs.

12. As Gartner recommended, the department should continue to improve the financial functionality of TFACTS to reduce the number of manual processes that personnel currently use to maintain financial reporting and to comply with Statewide Automated Child Welfare Information System requirements.

13. The department should continue to comply with both Gartner's and the Technical Assistance Committee's recommendations to ensure that codes originally written using OptimalJ are adequately maintained by trained personnel. If the department decides to stop using the OptimalJ codes, it should implement a plan to successfully transition the system.

14. The department should continue to improve and expand its in-house TFACTS training sessions for employees/users, including providing hands-on, department-wide training to ensure that all users are capable and confident with TFACTS.

15. The department should ensure that all required background check forms are completed, signed, and reviewed prior to approval. The department should review the existing policy, revise it as necessary, and provide additional training to ensure all employees are aware of and understand the policy and its requirements.

16. The department should also perform periodic reviews of a sample of background check files to help ensure background checks are appropriately completed and documented.

17. The department should reassess the information that needs to be maintained in a recipient's file to document eligibility and approval for Adoption Assistance (AA) and Subsidized Permanent Guardianship (SPG) payments, the appropriate payment amount, and review by management. The department should then review its policies to ensure the policy focuses on the necessary information, and should require that staff include that information in the files.

18. The department should consider performing periodic reviews on a random sample of AA and SPG files to help ensure completeness of files appropriateness of payments, and to identify areas where additional training is needed. Any overpayments identified should be recovered.

Division of Juvenile Justice

19. The department should take steps to ensure that the caseworkers adequately supervise youth who have been adjudicated delinquent and are on probation and aftercare, and that they properly perform YLS assessments or reassessments according to departmental policy. These steps should include retraining on these policies for Juvenile Justice caseworkers. Additionally, these caseworkers should be adequately

supervised and monitored by their team leaders and coordinators. The creation of management reports for probation and aftercare cases from TFACTS data will help make this monitoring more effective (see finding 5 for further discussion of this issue).

20. The department should conduct a needs assessment to determine residential treatment resources needed in the 12 regions to appropriately serve youth who have been adjudicated delinquent. Once the needs assessment is completed, network development staff should work with private providers and department management to determine how best to expand resources to provide youth the treatments, levels of placement, and security they need.

21. The department should also work with private providers to address concerns regarding the performance-based contract process. The baseline measurements should be evaluated, as should the relationship between performance-based contract standards and providers' selectivity when accepting youth for placement. The department should hold providers accountable for not accepting appropriate referrals.

22. The department should define, calculate, publish, and periodically update a custodial recidivism rate. In addition, the department should develop other effectiveness measures for youth who have been adjudicated delinquent and placed in DCS custody. Lastly, measures should be established to monitor the effectiveness of the probation and aftercare programs.

23. The department should work with all contracted private providers to continue implementation of the evidence-based law and should ensure that 100% of the funds expended for delinquent juveniles (i.e., all delinquency programs) meet the statutory requirements.

Division of Child Programs

24. The department should continue identifying and addressing additional placements and treatment resources needed for youth in foster care. As part of this effort, the department should conduct a formal needs assessment for each region of the state and then work with private providers and advocacy and community groups to determine how best to meet the additional needs identified.

25. The department also needs to continue developing mechanisms to monitor providers who may be informally denying services to children for solely economic reasons, which is in violation of provider-department agreements. If the department determines that such informal denials are occurring frequently, it should take steps to enforce contract provisions that require providers to accept all reasonable placements.

Appendix 1
Title VI and Other Information

The Tennessee Human Rights Commission (THRC) issues a report *Tennessee Title VI Compliance Program* (available on its website) that details agencies' federal dollars received, Title VI complaints received, whether each agency's Title VI implementation plan was filed in a timely manner, and any THRC findings that were taken on an agency. According to THRC's fiscal year 2013 report, the Department of Children's Services' Title VI implementation plan was received by the October 1, 2012, due date. No findings were identified in the department's implementation plan. During the plan's reporting period, THRC received and referred two complaints about the department.

The Department of Children's Services received $115,049,100 in federal funding for fiscal year 2012, and an estimated $113,686,200 in fiscal year 2013.

See below for a breakdown of the department's staff by job title, gender, and ethnicity.

Department of Children Services Staff Ethnicity and Gender
By Job Position
October 2013

Job Title	Male	Female	American Indian	Asian	Black	Hispanic	White	Other Ethnicity
Account Clerk	2	11	0	0	3	0	9	1
Accountant 2	2	2	0	0	1	0	3	0
Accountant 3	4	2	0	1	1	0	4	0
Accounting Manager	1	1	0	0	1	0	1	0
Accounting Technician 1	6	33	0	0	8	1	29	1
Accounting Technician 2	0	9	0	0	2	0	7	0
Administrative Assistant 1	0	2	0	0	0	0	2	0
Administrative Secretary	2	54	0	0	12	0	44	0
Administrative Services Assistant 1	0	1	0	0	0	0	1	0
Administrative Services Assistant 2	2	25	0	0	5	0	22	0
Administrative Services Assistant 3	2	21	0	1	3	0	19	0
Administrative Services Assistant 4	1	5	0	0	1	0	5	0
Administrative Services Assistant 5	1	3	0	0	2	0	2	0
Administrative Services Manager	5	8	0	0	4	0	9	0
Affirmative Action Director	1	0	0	0	0	0	1	0
Affirmative Action Officer 1	1	1	0	0	2	0	0	0
Application Architect	4	0	0	2	0	0	2	0
Assistant Commissioner 2	1	1	0	0	0	0	2	0

Job Title	Male	Female	American Indian	Asian	Black	Hispanic	White	Other Ethnicity
Attorney 3	14	46	0	0	5	1	53	1
Attorney 4	4	12	0	0	0	0	16	0
Audit Director 2	1	0	0	0	0	0	1	0
Auditor 2	2	2	0	0	2	0	2	0
Auditor 3	1	0	0	1	0	0	0	0
Auditor 4	1	0	0	0	0	0	1	0
Budget Analysis Director 1	1	0	0	0	0	0	1	0
Budget Analyst 2	1	0	0	0	0	0	1	0
Building Maintenance Worker 2	5	0	0	0	1	0	4	0
Building Maintenance Worker 3	2	0	0	0	0	0	2	0
Clerk 2	0	6	0	0	6	0	0	0
Clerk 3	2	13	0	0	7	0	8	0
Commissioner 2	1	0	0	0	0	0	1	0
Community Services Assistant	1	28	0	0	14	0	15	0
Correctional Principal	0	2	0	0	2	0	0	0
Correctional Teacher	18	28	0	0	20	0	26	0
Correctional Teacher Supervisor	2	0	0	0	1	0	1	0
Data Entry Operator	0	2	0	0	0	0	2	0
Database Administrator 3	1	0	0	0	0	0	0	1
DCS Administrative Services Manager	2	0	0	0	0	0	2	0
DCS Case Manager 1	46	229	0	1	92	0	181	1
DCS Case Manager 2	267	1314	5	6	601	12	945	12
DCS Case Manager 3	54	204	1	0	100	2	154	1
DCS Case Manager 4	51	318	0	0	138	1	229	1
DCS Corporal	38	22	0	0	41	0	19	0
DCS Executive Director 1	0	2	0	0	1	0	1	0
DCS Executive Director 2	0	2	0	0	1	0	1	0
DCS Institution Superintendent	1	2	0	0	2	0	1	0
DCS Lieutenant	6	7	0	0	7	0	6	0
DCS Officer	138	113	0	0	170	4	76	1
DCS Program Coordinator	6	39	0	0	13	0	32	0
DCS Program Director 1	5	14	0	0	3	0	16	0
DCS Program Director 2	4	4	0	0	1	0	7	0
DCS Program Director 3	2	5	0	0	0	1	6	0
DCS Program Manager	1	9	0	0	4	0	5	1

Job Title	Male	Female	American Indian	Asian	Black	Hispanic	White	Other Ethnicity
DCS Program Specialist	8	32	0	0	16	0	24	0
DCS Regional Administrator	0	11	0	0	1	0	10	0
DCS Security Manager	2	1	0	0	2	0	1	0
DCS Sergeant	9	6	1	0	9	0	5	0
DCS Special Investigator 2	2	0	0	0	1	0	1	0
DCS Special Investigator 3	2	2	0	0	2	0	2	0
DCS Team Coordinator	11	62	0	0	24	0	49	0
DCS Treatment Manager	2	1	0	0	1	0	2	0
Deputy Commissioner 2	2	1	0	0	0	0	3	0
Education Consultant 1	3	10	0	0	2	0	11	0
Education Consultant 2	4	3	0	0	1	0	6	0
Education Consultant 4	0	1	0	0	0	0	1	0
Eligibility Counselor 1	1	1	0	0	0	0	1	1
Eligibility Counselor 2	7	29	0	0	10	0	26	0
Executive Admin Assistant 1	1	0	0	0	0	0	1	0
Executive Admin Assistant 2	2	7	0	0	3	1	5	0
Executive Admin Assistant 3	2	3	0	0	2	0	3	0
Executive Secretary 1	0	1	0	0	1	0	0	0
Facilities Manager 1	3	0	0	0	0	0	3	0
Facilities Safety Officer 2	0	1	0	0	0	0	1	0
Facilities Safety Officer 3	1	0	0	0	0	0	1	0
Facility Administrator 3	0	1	0	0	0	0	0	1
Field Supervisor 2	0	2	0	0	1	0	1	0
Fiscal Director 1	4	3	0	0	1	0	6	0
Fiscal Director 2	1	3	0	0	0	0	4	0
Food Service Director 3	0	1	0	0	0	0	1	0
Food Service Manager 1	2	2	0	0	2	0	1	1
Food Service Steward 1	2	4	0	0	4	0	2	0
Food Service Steward 2	2	9	0	0	4	0	7	0
General Counsel 4	1	0	0	0	0	0	1	0
Graduate Associate	1	14	0	0	7	0	8	0
Graduate Trainee	0	4	0	0	2	0	2	0
HR Analyst 1	0	3	0	0	3	0	0	0
HR Analyst 2	0	12	0	0	3	0	8	1
HR Analyst 3	3	10	0	0	5	0	8	0
HR Director 2	0	3	0	0	1	0	2	0

Job Title	Male	Female	American Indian	Asian	Black	Hispanic	White	Other Ethnicity
HR Director 3	1	0	0	1	0	0	0	0
HR Director 4	0	1	0	0	0	0	1	0
HR Manager 1	0	1	0	0	0	0	1	0
HR Manager 2	0	1	0	0	1	0	0	0
HR Technician 1	0	2	0	0	0	0	2	0
HR Technician 2	0	5	0	0	0	0	5	0
HR Technician 3	0	3	0	0	1	0	2	0
Information Resource Support Specialist 2	15	14	0	0	12	0	17	0
Information Resource Support Specialist 3	3	1	0	0	2	0	2	0
Information Resource Support Specialist 4	2	5	0	0	2	0	5	0
Information Resource Support Specialist 5	3	0	0	0	1	0	2	0
Information Systems Analyst 3	1	3	0	0	2	0	2	0
Information Systems Analyst 4	2	1	0	1	1	0	1	0
Information Systems Analyst Supervisor	0	2	0	0	0	0	2	0
Information Systems Consultant	1	1	0	0	0	0	2	0
Information Systems Director 1	0	2	0	0	0	0	2	0
Information Systems Director 2	2	0	0	0	0	0	2	0
Information Systems Director 3	2	0	0	0	1	0	1	0
Information Systems Manager 1	4	2	0	0	3	0	3	0
Information Systems Manager 2	1	0	0	0	0	0	1	0
Information Systems Manager 3	2	1	0	0	0	0	3	0
Information Systems Technical Consultant	2	0	0	0	0	1	1	0
Legal Assistant	0	10	0	0	1	0	9	0
Legal Services Director	0	1	0	0	0	0	1	0
Licensed Practical Nurse 2	0	8	0	0	6	0	2	0
Licensed Practical Nurse 3	0	6	0	0	1	0	5	0
Maintenance Mechanic 2	1	0	0	0	0	0	1	0
Mental Health Practitioner	1	0	0	0	0	0	1	0
MH/IDD Standards Coordinator	0	1	0	0	1	0	0	0
Office Supervisor 1	0	1	0	0	0	0	1	0
Physician - Psychiatrist	0	1	0	0	0	0	1	0
Procurement Officer 1	0	2	0	0	1	0	1	0
Procurement Officer 2	1	2	0	0	0	0	3	0
Program Monitor 2	0	4	0	0	3	0	1	0

Job Title	Male	Female	American Indian	Asian	Black	Hispanic	White	Other Ethnicity
Program Monitor 3	0	1	0	0	0	0	1	0
Program Monitor 4	0	1	0	0	0	0	1	0
Programmer/Analyst 3	4	0	0	1	0	0	3	0
Programmer/Analyst 4	8	6	1	4	2	0	6	1
Programmer/Analyst Supervisor	1	1	0	0	1	0	1	0
Psychiatric Chaplain 2	1	0	0	0	0	0	1	0
Psychologist	4	6	0	0	1	0	9	0
Public Health Nursing Consultant 1	1	9	0	1	1	0	8	0
Public Health Nursing Consultant 2	0	4	0	0	1	0	3	0
Recreation Specialist 2	2	0	0	0	0	0	2	0
Registered Nurse 3	1	2	1	0	1	0	1	0
Registered Nurse 4	0	3	0	0	0	0	3	0
Registered Nurse 5	0	1	0	0	0	0	1	0
Secretary	1	134	0	0	37	1	97	0
Security Guard 1	1	0	0	0	1	0	0	0
Senior Project Manager	1	2	0	0	1	0	2	0
Statistical Analyst 3	0	1	0	0	1	0	0	0
Statistics Assistant Director	0	1	0	0	1	0	0	0
Storekeeper 2	1	1	0	0	0	0	2	0
Stores Clerk	1	1	0	0	1	0	1	0
Teacher's Assistant - Correction	1	7	0	0	6	0	2	0
Training and Curriculum Director 1	0	5	0	0	1	0	3	1
Training and Curriculum Director 2	0	2	0	0	2	0	0	0
Training Officer 1	2	23	0	0	10	0	14	1
Training Officer 2	1	6	0	0	2	0	5	0
Training Specialist 2	2	2	0	0	1	0	3	0
Vocational Instructor-Per Specialty	9	3	0	0	4	0	8	0
Total	**877**	**3,148**	**9**	**20**	**1,499**	**25**	**2,444**	**28**

Appendix 2
Performance Measures Information

In April 2013, the Tennessee General Assembly passed, and the Governor approved, the Tennessee Governmental Accountability Act of 2013, which changed the state's process for developing, reporting, and monitoring performance measures. As part of the new performance measurement process, the Department of Children's Services (DCS) developed new strategic measures. The department's priority goals, as reported for October 2013 on the Governor's Customer Focused Government website are as follows.

Performance Standard 1: Improve the percentage of Child Protective Services (CPS) special investigations unit (SIU) cases closed in 60 days to 80%.

Purpose of Goal: To ensure the safety of children and to align with the Brian A. lawsuit standard.

Measuring the Goal: Percent of CPS-SIU cases closed in 60 days:

Baseline	**Current**	**Target**
70%	73.7%	80%

Source: TFACTS (DCS database) case entries. The data is aggregated into a report called "Open CPS Investigations by Case Age" and is published in SharePoint.

Performance Standard 2: Improve priority response times for CPS-SIU investigations.

Purpose of Goal: To ensure the safety of children and to align with the Brian A. lawsuit standard.

Measuring the Goal:

	Baseline	**Current**	**Target**
Percent of priority 1 responses met	70%	TBD	80%
Percent of priority 2 responses met	70%	TBD	80%
Percent of priority 3 responses met	70%	TBD	80%

Source: TFACTS (DCS database) case entries.

Performance Standard 3: Improve the efficiency of the Child Abuse Hotline.

Purpose of Goal: Fewer dropped calls translate into more child abuse being reported, which further promotes the safety of children.

Measuring the Goal:

	Baseline	**Current**	**Target**
Number of calls answered in 20 seconds or less	60%	80%	80%
Percent of dropped hotline calls	20%	10%	5%

Source: The Cisco System (monitors and collects phone data for the Child Abuse Hotline).

Performance Standard 4: Increase the overall percentage of child permanency.

Purpose of Goal: Permanency is the goal for all children in DCS custody. This means they are in a permanent, healthy, and safe home. This is also a requirement for the Brian A. lawsuit.

Measuring the Goal: Percent of children reunified with families within 12 months.

Baseline	**Current**	**Target**
71.7%	67%	80%

Source: TFACTS reports.

Appendix 3
Audit Objectives

The objectives for the audit of the Divisions of Child Safety and Child Health were to

1. assess whether Child Safety investigations are completed as thoroughly as reasonably possible within existing guidelines and how investigations can be improved, including whether the current investigator caseload guidelines are appropriate and whether major substantiation policy language is consistent with statutory language;
2. assess whether Child Protective Investigative Teams are meeting their objectives and how they can be improved, especially in terms of attendance;
3. review how effectively the Child Abuse Hotline receives and classifies all referrals (to the extent possible), how the department is refining its operations, and if/how its operations can be further improved;
4. assess whether the department complies with key statutory legislative reporting requirements; and
5. identify and assess, to the extent possible, changes made to the child death review process.

The objectives for the audit of the administrative functions were to

1. determine to what extent the department's Office of Information Systems has adequately addressed the user or management problems associated with the Tennessee Family and Child Tracking System (TFACTS);
2. assess whether the department has adequately monitored that background checks are being completed for the persons who have significant contact with children;
3. determine whether state-funded adoption assistance and subsidized permanent guardianship payments were correctly made for eligible children;
4. determine how complaints from parents about missing, duplicate, or over payments are tracked, and to determine what steps are taken by the department's fiscal staff to remedy these identified payment errors in a timely manner; and
5. determine what steps the Office of Information Systems has taken to obtain a technical review of TFACTS, as recommended by the March 2012 Comptroller's report on the implementation of TFACTS.

The objectives for the audit of the Division of Juvenile Justice were to

1. determine whether caseworkers are adequately supervising youth on probation or aftercare;
2. assess the availability of placement options appropriate for youth who have been adjudicated delinquent;
3. review the department's definition of recidivism, the procedure established for calculating the recidivism rate, and recidivism data;
4. determine how the department knows the treatment services provided to youth who have been adjudicated delinquent are effective;
5. determine how the department ensures that treatment services provided to youth in custody who have been adjudicated delinquent are evidence-based programs; and
6. assess whether the availability of services for youth who have been adjudicated delinquent and are on state probation or aftercare are sufficient.

The objectives for the audit of the Divisions of Child Programs were to

1. determine and assess the process of placing youth in resource (foster) homes and other out-of-home care;
2. determine and assess the process for recruiting resource homes;
3. determine if the department intends to continue Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screenings in light of the John B. lawsuit exit and, if so, to determine and assess how the department ensures these screenings occur;
4. determine and assess how the department monitors whether caseworkers comply with visitation requirement for children in out-of-home care;
5. determine the extent to which the department expanded its foster care program and how children in the extended program are monitored; and
6. determine and assess the process used to screen and otherwise intake new resource parents.

Appendix 4
Child Abuse Hotline
Call Center Report
(January 1, 2013 through September 30, 2013)

Source: Department of Children's Services, Office of Child Safety – Child Abuse Hotline.

	Service Level	Handled Calls <SL	Abandon Calls <SL	Without Abandon SL %	Calls Presented	Handled Calls	% Handled Calls	Abandon Calls	% Abandon Calls	Calls Dequeue	% Calls Dequeue	% Abandon Calls Over SL	Calls Holding Over 5 Minutes	0 Second Abandon Calls	Abandon Rate > 0 Second	Avg Speed To Answer
Jan-13	3	1,496	148	12.30%	12,312	11,757	95.49%	548	4.45%	5	0.04%	3.25%	144	23	4.27%	0:00:27
Feb-13	3	1,608	126	13.09%	12,411	11,835	95.36%	571	4.60%	4	0.03%	3.59%	102	26	4.40%	0:00:27
Mar-13	0	8,239	193	65.85%	12,704	12,216	96.16%	479	3.77%	7	0.06%	2.25%	35	32	3.53%	0:00:19
Apr-13	10	10,954	239	77.40%	14,392	13,814	95.98%	573	3.98%	4	0.03%	2.32%	63	28	3.79%	0:00:23
May-13	10	11,291	210	80.45%	14,244	13,766	96.64%	476	3.34%	1	0.01%	1.87%	46	34	3.11%	0:00:20
Jun-13	0	9,914	191	84.77%	11,886	11,461	96.42%	419	3.53%	5	0.04%	1.92%	60	20	3.36%	0:00:19
Jul-13	20	9,993	265	78.65%	12,971	12,351	95.22%	616	4.75%	4	0.03%	2.71%	74	34	4.50%	0:00:26
Aug-13	20	10,694	290	72.67%	15,006	14,245	94.93%	758	5.05%	3	0.02%	3.12%	135	28	4.87%	0:00:33
Sep-13	20	10,228	246	74.23%	14,025	13,408	95.60%	611	4.36%	6	0.04%	2.60%	90	27	4.17%	0:00:30
Oct-13																
Nov-13																
Dec-13																
Total		**74,417**	**1,908**	**63.04%**	**119,951**	**114,853**	**95.75%**	**5,051**	**4.21%**	**39**	**0.03%**	2.62%	749	**252**	4.01%	**0:00:24**

March Change from 3 to 10 second service level
June Change from 10 to 20 second service level

Appendix 5
Child Abuse Hotline
Week-Over-Week Call Summary for 2012 and 2013
(January 1 through September 30 Comparison)

Source: Department of Children's Services, Office of Child Safety – Child Abuse Hotline.

	2012				2013				Year-Over-year					
Week of	Calls Presented	Calls Handled	Calls Abandoned	Abandon %	Week of	Calls Presented	Calls Handled	Calls Abandoned	Abandon %	Increased Calls Presented	% Change Calls Presented	Increased Calls Handled	% Change Calls Handled	Increased Calls Abandoned	% Change Calls Abandoned
1-Jan	2,861	2,242	618	21.6%	30-Dec	2,077	1,987	89	4.3%	(784)	-27.4%	(255)	-11.4%	(529)	-85.6%
8-Jan	3,194	2,613	581	18.2%	6-Jan	2,897	2,767	129	4.5%	(297)	-9.3%	154	5.9%	(452)	-77.8%
15-Jan	3,249	2,512	737	22.7%	13-Jan	2,683	2,549	130	4.8%	(566)	-17.4%	37	1.5%	(607)	-82.4%
22-Jan	3,685	2,839	843	22.9%	20-Jan	2,706	2,582	124	4.6%	(979)	-26.6%	(257)	-9.1%	(719)	-85.3%
29-Jan	3,385	2,693	692	20.4%	27-Jan	3,042	2,896	145	4.8%	(343)	-10.1%	203	7.5%	(547)	-79.0%
5-Feb	3,658	2,699	958	26.2%	3-Feb	3,292	3,077	213	6.5%	(366)	-10.0%	378	14.0%	(745)	-77.8%
12-Feb	3,677	2,678	998	27.1%	10-Feb	3,108	2,994	114	3.7%	(569)	-15.5%	316	11.8%	(884)	-88.6%
19-Feb	3,471	2,612	859	24.7%	17-Feb	2,981	2,870	110	3.7%	(490)	-14.1%	258	9.9%	(749)	-87.2%
26-Feb	3,406	2,630	774	22.7%	24-Feb	3,034	2,908	124	4.1%	(372)	-10.9%	278	10.6%	(650)	-84.0%
4-Mar	3,534	2,691	843	23.9%	3-Mar	3,084	2,954	125	4.1%	(450)	-12.7%	263	9.8%	(718)	-85.2%
11-Mar	3,200	2,537	663	20.7%	10-Mar	2,980	2,863	117	3.9%	(220)	-6.9%	326	12.8%	(546)	-82.4%
18-Mar	3,636	2,629	1007	27.7%	17-Mar	3,083	2,948	133	4.3%	(553)	-15.2%	319	12.1%	(874)	-86.8%
25-Mar	3,680	2,708	972	26.4%	24-Mar	2,698	2,614	82	3.0%	(982)	-26.7%	(94)	-3.5%	(890)	-91.6%
1-Apr	3,088	2,405	682	22.1%	31-Mar	3,007	2,909	95	3.2%	(81)	-2.6%	504	21.0%	(587)	-86.1%
8-Apr	3,588	2,618	968	27.0%	7-Apr	3,363	3,255	108	3.2%	(225)	-6.3%	637	24.3%	(860)	-88.8%
15-Apr	3,780	2,762	1017	26.9%	14-Apr	3,459	3,297	161	4.7%	(321)	-8.5%	535	19.4%	(856)	-84.2%
22-Apr	3,463	2,780	669	19.3%	21-Apr	3,294	3,160	133	4.0%	(169)	-4.9%	380	13.7%	(536)	-80.1%
29-Apr	4,167	3,245	904	21.7%	28-Apr	3,458	3,304	154	4.5%	(709)	-17.0%	59	1.8%	(750)	-83.0%
6-May	3,817	3,181	633	16.6%	5-May	3,390	3,278	112	3.3%	(427)	-11.2%	97	3.0%	(521)	-82.3%
13-May	3,579	2,850	735	20.5%	12-May	3,401	3,273	128	3.8%	(178)	-5.0%	423	14.8%	(607)	-82.6%
20-May	3,109	2,765	344	11.1%	19-May	3,126	3,024	101	3.2%	17	0.5%	259	9.4%	(243)	-70.6%
27-May	2,555	2,402	152	5.9%	26-May	2,588	2,511	75	2.9%	33	1.3%	109	4.5%	(77)	-50.7%
3-Jun	2,672	2,529	144	5.4%	2-Jun	2,804	2,725	78	2.8%	132	4.9%	196	7.8%	(66)	-45.8%
10-Jun	2,855	2,666	189	6.6%	9-Jun	2,803	2,698	103	3.7%	(52)	-1.8%	32	1.2%	(86)	-45.5%
17-Jun	2,725	2,565	159	5.8%	16-Jun	2,982	2,859	123	4.1%	257	9.4%	294	11.5%	(36)	-22.6%
24-Jun	3,055	2,782	271	8.9%	23-Jun	2,852	2,753	97	3.4%	(203)	-6.6%	(29)	-1.0%	(174)	-64.2%
1-Jul	2,483	2,391	94	3.8%	30-Jun	2,264	2,172	91	4.0%	(219)	-8.8%	(219)	-9.2%	(3)	-3.2%
8-Jul	3,116	2,829	286	9.2%	7-Jul	2,991	2,859	132	4.4%	(125)	-4.0%	30	1.1%	(154)	-53.8%
15-Jul	2,973	2,739	233	7.8%	14-Jul	2,999	2,839	158	5.3%	26	0.9%	100	3.7%	(75)	-32.2%
22-Jul	3,271	2,911	360	11.0%	21-Jul	2,998	2,867	131	4.4%	(273)	-8.3%	(44)	-1.5%	(229)	-63.6%
29-Jul	2,916	2,712	203	7.0%	28-Jul	2,920	2,770	149	5.1%	4	0.1%	58	2.1%	(54)	-26.6%
5-Aug	3,291	2,932	360	10.9%	4-Aug	3,187	3,057	128	4.0%	(104)	-3.2%	125	4.3%	(232)	-64.4%
12-Aug	3,490	3,013	476	13.6%	11-Aug	3,450	3,246	204	5.9%	(40)	-1.1%	233	7.7%	(272)	-57.1%
19-Aug	3,574	3,056	518	14.5%	18-Aug	3,502	3,329	173	4.9%	(72)	-2.0%	273	8.9%	(345)	-66.6%
26-Aug	4,177	3,390	792	19.0%	25-Aug	3,690	3,478	211	5.7%	(487)	-11.7%	88	2.6%	(581)	-73.4%
2-Sep	3,346	2,714	629	18.8%	1-Sep	3,156	3,008	147	4.7%	(190)	-5.7%	294	10.8%	(482)	-76.6%
9-Sep	3,537	2,928	607	17.2%	8-Sep	3,438	3,286	150	4.4%	(99)	-2.8%	358	12.2%	(457)	-75.3%
16-Sep	3,581	2,947	634	17.7%	15-Sep	3,352	3,181	171	5.1%	(229)	-6.4%	234	7.9%	(463)	-73.0%
23-Sep	3,483	3,040	621	17.8%	22-Sep	3,274	3,159	112	3.4%	(209)	-6.0%	119	3.9%	(509)	-82.0%
30-Sep	3,180	2,801	379	11.9%	29-Sep	3,125	2,995	130	4.2%	(55)	-1.7%	194	6.9%	(249)	-65.7%